# Old Age Psychiatrist Newsletter of the Old Age Faculty of the Royal College of Psychiatrists

**June 2016 Issue 65**

**Editorial Team: Helen McCormack, Sharmi Bhattacharyya, Anitha Howard, Ayesha Bangash**

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## Update from the Editorial Team, Helen McCormack,

**helenjmccormack@hotmail.co.uk**

As a new editorial team, we are pleased to have published our first newsletter in January 2016. We will be monitoring activity on the website with the help of the IT department, both to identify the number of hits the newsletter has but also the time people are spending looking at it. We would welcome other sources of feedback, so please get in touch to tell us what you like, what you don't like, and what you would like more of.....

We are also pleased to have appointed a Trainee editor, Dr Ayesha Bangash who joined the team on March 1st 2016. Ayesha is an ST4 Trainee in Old Age Psychiatry, working in Coventry, and will be working with us for a twelve month period. She previously worked as a core psychiatry trainee in Shropshire where she had opportunities to participate in dementia research, teach school children about dementia and have 3 years experience as the junior doctors' representative. Her interests are the peri-diagnostic support of dementia and doing anything to popularize old age psychiatry.

We have put together a varied newsletter, including reflections from the recent Old Age Faculty Conference, one of which is from June Terry , carer representative, attending the conference for the first time.

We also publish our first article from a member of the British Geriatric Society (BGS), 'Wielding the Geriatrician's Scalpel: Top Tips for Pharmacological Debridement, by James Fisher, Specialist Registrar in Geriatric and General Internal Medicine. We hope this to be the beginning of a strengthened partnership with the BGS, sharing experiences and promoting collaboration. If there are any topics you would like them to cover for us we would love to hear from you.

We are pleased to publish the winner of the Medical Student Essay prize, announced at the recent Old Age Faculty Conference in Nottingham.

The Faculty established this prize in order to raise the profile of old age psychiatry and to encourage medical students to pursue further study and professional training in this area. Eligible students are invited to submit an original essay of up to 5000 words on any aspect of old age psychiatry, and it attracts a £250 prize. We hope you enjoy the essay.

We also announce our own essay competition, for qualified doctors, and hope you will find the topic, 'Old Age Psychiatry: how I see it 20 years from now', interesting and relevant.

## Competition for all doctors!

### £150 for the winner and £50 for the runner up!

*Old Age Psychiatrist* wants to hear your views on the following theme:

**Old age psychiatry: how I see it 20 years from now.**

What are the future challenges for old age psychiatry?
Is this specialty flourishing or in danger of becoming extinct?
How do we respond to the changing needs of the older population?
What will the role of the old age psychiatrist be?

Creative or original writing welcome (including essays, short stories, personal accounts and poems) with word limit up to 1000 words.
For doctors ranging from foundation trainees to consultants.

Winners to be announced at the Old Age Psychiatry Faculty Conference in March 2017 and 5 short-listed entries (including those of the winners) to be published in the May 2017 edition of *Old Age Psychiatrist.*

**Please email your submissions to Ayesha Bangash, trainee editor at 520ayesha@gmail.com by 30th September 2016 along with your names, grades, work addresses and contact phone numbers.**

## Update from Alistair Burns

**NHS England's National Clinical Director for Dementia and Older People's Mental Health**

These last few months has, as always, been a busy and thought provoking time for me as your National Clinical Director for Dementia and Older People's Mental Health. Most recently, it was a great meeting in Nottingham (thanks very much to the hosts and organisers) and a pleasure to chair the debate (fascinating to hear the idea discussed around a "pilot revolution"- something I will bear in mind!) I get asked a lot about old age psychiatry and it is very helpful to say confidently that our discipline is in rude health.

In the last few weeks there has been two major reports announced which have specific relevance to us. In January 2016, the Mental Health Task Force reported (1) and I know this is something that we have had a number of discussions and debates upon in the recent past. Old age psychiatry got a fair few mentions (understandably the majority of the substance related to general adult psychiatry and because of recent developments, child and adolescent mental health) but the clear message (supported strongly by the Chair Paul Farmer) was that this was an all age for us. Gaining specific recognition of the skills for old age psychiatry in physical health care was important as was the recognition of the success of the Commissioning for Quality and Innovation (CQUIN) for dementia and the recommendation that a similar depression CQUIN should be implemented. There is a specific focus on older people with depression, something which the Faculty has been highlighting for a number of years. Importantly, there is recognition that age specific service for older people is the preferred model. The report states 'older people should be able to access services that meet their needs – bespoke older adult services should be the preferred model until general adult mental health services can be show to provide age appropriate care'. So, lots for us to think about and act upon. We are working on a digestible form to highlight what are the specific issues relating to old age that we can take forward.

The implementation plan of the Prime Minister's 2020 Challenge on Dementia was published a few weeks later (2). There is a raft of information there around dementia care and specific areas of importance include: risk reduction (and using the NHS Health Check to highlight that there are things which can be done to prevent dementia); a drive to increase the number of people with dementia involved in research (a specific ambition that 10% of people with dementia should be involved in research and that 25% of people should have been given the opportunity to take part in research by signing up to "Join Dementia Research"(3) is a good way of fulfilling this. The Dementia Friends initiative should be extended to encompass dementia friendly communities and dementia friendly businesses. There is a specific ambition that there will be 4 million dementia friends by 2020. Are all readers dementia friends? You should be and it is easy to achieve (4).

The increase in interest in dementia has attracted the concern (raised by a recent survey in Pulse Magazine (5) and mentioned at our conference) that many people referred to memory clinics are younger and turn out not to have dementia. Services are memory assessment clinics rather that dementia diagnosis clinics and if someone is concerned they have a memory loss then they have every right to be investigated. I am not sure if I would see it a s sign of failure if someone is worried about their memory, comes for an assessment and after proper investigation and assessment, it turns out they do not have dementia. Would the same view be taken if this was a physical illness I wonder? I know there are concerns about waiting lists and pressures on memory clinics. We are working with the National Collaborating Centre for Mental Health on an access standard for dementia which would be across the pathway and would be more than simply looking at a suggested waiting time for an assessment and diagnosis at a memory clinic. Dementia diagnosis rates continue to achieve our national ambition and the current national rate is 67.4%. As you may have seen, the Enhanced Service for the assessment of dementia in primary care was stopped in the last few weeks.

So, as always, these are challenging times but there are lots of opportunities, it is a great privilege to go around the country and talk with individual clinicians and to see their service sat first hand. Please write to me (Alistair.Burns@manchester.ac.uk) with any thoughts, comments or invitations.

Quiz

I was recently in the Isle of Man at a great meeting organised by the Alzheimer's Society (this is the singing for the brain session). There were 250 people there. Proportionately, if the same number had been there at a meeting in England, what would have been the size of the audience?

a) 16,000
b) 160,000
c) 1.6 million

1. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
2. https://www.gov.uk/government/publications/challenge-on-dementia-2020-implementation-plan
3. https://www.joindementiaresearch.nihr.ac.uk/

4. *https://www.dementiafriends.org.uk/*
5. *http://www.pulsetoday.co.uk/clinical/more-clinical-areas/neurology/inappropriate-gp-dementia-referrals-double-since-introduction-of-case-finding-des/20009264.fullarticle*

## **Update from James Warner**, Chair of the Old Age Faculty.

Four years ago, during what politicians when caught with their trousers down would call "a moment of madness", I decided to bid for the Chair of the faculty. Given no one else stood for this office, I got in without an election having no idea what lay ahead.

It's been amazing. Surrounded by energetic, motivated people that form the executive has provided real opportunity to change and hopefully improve old age psychiatry. What I won't do is list the things we have achieved except to say that needs-based definition of the speciality is now firmly established with only 30% of services nationally defining their remit by age; ageless services are in retreat (over 40% of previously ageless services have reverted to age specific) as evidence mounts they cause harm; and new job planning guidance http://www.rcpsych.ac.uk/pdf/FROA03.pdf is proving a real help to our members as the complexity of our work mounts.

But for me the sweetest victory is the recognition that old age liaison trainees should have endorsement for their liaison training. The righting of this inexplicable iniquity took nearly all of my time in office. Credit for this goes to Ann Boyle, Wendy Burn and our colleagues in the liaison faculty who were pivotal in driving the process. Although a relatively small achievement, this inequality exemplified age discrimination; something that remains a pernicious and corrosive force in healthcare today. So the principle of righting this wrong became symbolic as well as helping trainees gain the recognition they deserve.

Anyone who was at our fabulous annual conference in Nottingham this March will testify to the faculty being not only alive and well, but kicking. It is important not to lose this momentum. There are many threats in the future that the faculty needs to address: uptake of training remains doggedly low at around 60% (but similar to all psychiatry specialties); chronic underfunding will become more of an issue if we adopt tariff based commissioning unless funding takes into account our recent research showing older people cost over 25% more to treat compared with younger adults. For me the most dangerous threat is integrated care. The trouble is no one really knows what this is, and what unintended consequences will accrue form the imposition of the ideology. Don't get me wrong, I am fully supportive in integration if it means older people have to navigate fewer front doors to access care. I recently counted how many front doors- there were 22 including all primary and secondary care social services and voluntary sector in one London Borough. Fully aware of this threat, the faculty has commissioned a comprehensive assessment of integrated care, led by Helen McCormack, so we can be at the forefront of policy and practice, not on the back foot.

I have learned a few things along the way. Most politicians listen but don't hear, or care. Evidence is the best argument (so thanks to all of you that responded to our two national surveys). Change takes time and can only be achieved with flexibility and diplomacy (neither my strong suits).

I'll close by saying a huge thank you to all my friends and colleagues who have helped along the way, and wishing the faculty well in the future. I do hope to get old and will have a 30% chance of getting a mental illness so it's really important the specialty thrives.

## A call to arms: Conference Update, Sharmi Bhattacharyya and Anitha Howard.

The Old Age Faculty Annual meeting kicked off on Wednesday 9th March 2016 in Nottingham with a number of varied and interesting workshops from post diagnostic support to end of life care in dementia . Integrated care and integration was the theme but we attended an interesting workshop on medicolegal reports which helped us to brush up on our knowledge.

John O'Brien's update on NICE and offers of glasses of champagne to quiz winners was nice start to Thursday but Rob Howard's offer of a bottle of champagne to quiz winners was even better! His practical guidance on use of antipsychotics in Older Adults was helpful and reassuring to us jobbing Old Age Psychiatrists. The audience was reminded by Jordi Serra-Mestress' talk on Neuropsychiatric assessments that we are medics as well psychiatrist.

**Chair Dr James Warner and Vice Chair Dr. Sandra Evans**

A lively reflection from the Chair of the Old age Faculty, Dr Warner on the return of Age specific services and was welcomed by the audience as was his call to arms to help influence the direction and future of old age psychiatry. Lunch was time well spent on networking, viewing posters or meeting up with old friends followed by range of workshops in the afternoon. The Debate on 'Care and Older Peoples Mental Health-Revolution is the only way forward' made us reflect on whether we need to change the way we work.

On the last day Professor Burns as usual charmed us with his humour but on a serious note the audience welcomed his reflections that Old Age Psychiatry had more to offer than just dementia care. A point reinforced by James Morris, MP and head of the All parliamentary committee on mental health in his speech and we welcome his idea of a possible taskforce for older persons mental health. Baroness Elaine Murphy who won the Lifetime Achievement Award helped shed light on the mysterious ways that parliament works but it was her humour that kept the audience enthralled.

**Baroness Elaine Murphy**

The new research and the poster presentations showcased a range of topics encompassing research, economics, audit, music therapy, policy and elephants with BPSD.

**The winners are**

**The Mohsen Naguib Prize**

**Paul Donaghy**

**The phenotype of mild cognitive impairment due to Lewy Body disease**

**Poster presentation prize**

**Girish Rao**

**Clinical audit on advice given on driving for patients with dementia**

The take home message was once again that although Old Age Psychiatry has been declared as one of the ‘ shortage’ specialties, those working in it are committed, dedicated and excited to take the specialty forward.

## A personal reflection of my experience at The Faculty of Old Age Psychiatry Annual Conference 2016, June Terry.

**Representative of The Old Age Faculty Patient Carer Forum.**

My journey began saying goodbye to my two Labrador Collie crosses Doogle and Blue in Carlisle Cumbria. For once my Satnav behaved herself & got me to the East Midlands Conference Centre, Nottingham, without a hitch three hours later. As someone with rheumatoid arthritis, I was greatly relieved that disabled parking & the Orchard Hotel were all very close with easy access. Both hotel & conference centre are stunning & pristine with free coffee & good filtered bottled water easily accessible, very welcome.

The Faculty of Old Age Psychiatry Annual Conference 2016 was actually my first venture away from home alone. After many years juggling caring for my late husband with multiple sclerosis, running a horticultural nursery whilst raising three children ( all now doing well in their 20’s), it was all a bit daunting but I was determined to go as a representative to the Old Age Faculty of The Patient Carer Forum, and make my children proud. I am presently primary carer to my 86 year old mother (also June)who has Alzheimers & whom I have just moved into a beautiful sheltered apartment, so I am on the *front line* in my caring role & have been for, it seems, a lifetime.

On Wednesday 9th March co-representative of the Patient Carer forum Pippa Jones & I attended the executive committee & regional representatives of the Faculty of the Psychiatry of Old Age Meeting.

I braced myself to read a report which I had written myself out loud to a room full of learned delegates & raised the issue that there is a shortfall of *decent & free* Dementia Courses available specifically to individuals caring for family members; most available courses are closed to individuals unless employed in care, or are too far away (as in the case for Carlisle),or are prohibitively expensive. I raised and discussed the problem from my own perspective as a carer in Carlisle ,Cumbria but that any such courses should be available nationally. I confirmed the 'Dementia Friends course' run by The Alzheimers Society did not go nearly far enough which was acknowledged. I also raised the point that there is an army with firsthand experience 'out there' & certification for them would not only provide valuable recognition for the carers themselves but they could *later* use such a certificate as a stepping stone to gain employment in the care sector if desired & able. I was able to discuss this subject with other delegates informally throughout the two days). I was conscious that a very nice guy called Tim Beanland from the Alzheimers Society was at the Executive Committee meeting and he later mentioned C.R.I.S.P. courses which sound great but I know haven't been offered in Carlisle in the 18 months I have lived here. I requested Tim remind the Alzheimers Society that C.R.I.S.P. courses must come to Carlisle, not just Kendal which (unlike Carlisle)is *not* the capital of the Lakes & two hours away from everyone in North Cumbria! He told me it comes down to council funding and I should get names together to put pressure on. Good idea, but yet another job for my 'to do' list which is all I need!

I have never been taught or had experience in presenting my own report like this before so I was both excited & terrified. I was relieved to get through it and nobody laughed! Co-representative of the patient carer forum Pippa Jones kindly took notes for the forum. The chairman kindly said 'we are all equal here', which was greatly appreciated.

Everyone in the conference room was very gracious & also patient when I couldn't resist the urge to request clarification on other matters which I knew very little about but was none the less fascinated to hear academics discussing. The chairman, James Warner, was excellent, approachable and highly regarded. A lovely lady called Nori Graham was very interested when I spoke about my mother's new sheltered home Heysham Gdns & Meadows in Carlisle which helped me feel I brought something more to the meeting (it is so good it should be a model).

I also went on a workshop called 'What should Psychiatrists know about Arts Interventions in Dementia?' That was interesting and the group shared two dimensional and three dimensional experiences including singing gospel music in a round which was great fun, to tablet visual interactions e.g. touching Koy Carp in a pond and my favourite, playing a guitar …Yes really and for someone who never had the opportunity to learn to play a musical instrument, this would keep me amused for hours!!!!

I absolutely loved being one of three Judges of the poster competition (c. 60!!!) in the banqueting suite for a couple of hours; they were of very high standard (I am also a professional artist so know my stuff about artistic presentation)! The lunch & drinks ,both alcoholic & fresh orange options, in the afternoon were very welcome. That evening, I felt honoured to be a guest at the conference dinner in The Atrium which was excellent, even for a vegetarian like me and again I was made to feel very welcome, good food & great company, thank you.

All the lovely delegates I met at the conference will know by now I am not short of words ,so I hope my artistic eccentricities will not frighten them off from talking to me next time (if I am invited back)!

Many thanks to all concerned for a great experience.

Special thanks to Kitti Kottasz & Helen McCormack.

## Young-onset dementia, Keith Oliver.

**Kent & Medway NHS Partnership Trust Dementia Envoy, Alzheimer's Society Ambassador**
**Patient Member of the Royal College of Psychiatrists Exec Board for Older People**

For the past five years I have knowingly been increasingly sharing my brain with an unwelcome and unwanted guest; Dr. Alzheimer. As someone diagnosed with Alzheimer's Disease on New year's Eve 2010 at the age of 55 I am host to this insidious visitor. Others who share my life are so much more welcome and friendly amongst whom are my wife, my three adult children and my three grandchildren. Others who have entered my life since being diagnosed, and have made such a positive impact upon me include other service users and some wonderful professionals working in the NHS and in the voluntary sector.

When diagnosed I had the typical impression that dementia was solely the domain of the elderly. My mother developed Alzheimer's in her mid-70s and she was typical of how I imagined people with dementia. Never had I met someone affected by dementia below the age of 65. My diagnosis was very unexpected for myself, my family and our GP who had sent me for a scan and a neurologist appointment to rule out a brain tumour. Dementia wasn't on anybody's radar until after the scan and the appointment, following which I was referred to the memory clinic in Canterbury for what turned out to be an in-depth 6 month assessment period which culminated with a confirmed diagnosis. During this period I was extremely well supported by the professional team who explained to me the testing and the results of the tests which at best I was performing at average and at my worst at the lower fifth centile. The pacing and the approach were both person-centred. I wanted information and needed this to understand what I was living with, and subsequently this served to allow me to come to terms with moving from a suggested diagnosis to a confirmed one with less of a shock and then to begin to live well with dementia. No one, especially someone in their 50s wants to be diagnosed with dementia but because of the impact the disease was having on me by way of my ability to undertake my work, remember conversations and reading, TV programmes, films etc., changes in my behaviour and concentration and difficulties with balance there was some peace of mind in knowing what the cause of these problems was. From this, one is then able to move forward by sorting out a smooth exit from work, financial support, lasting power of attorney and wills and beginning to meet other people who were sharing the same or similar experience.

I then felt that information was exerting power over the disease and that I realised that I wasn't alone. Indeed one morning I woke up to open the newspaper and read that my understanding of there being 16,000 people with young onset dementia was incorrect and that the Alzheimer's Society were suggesting the figure is 42,000. Some would say this is an underestimate and I have heard figures around 65,000 (SCIE) which is probably more accurate as many people either don't or won't come forward or are mis-diagnosed.

The vast majority of people in their 40s, 50s and early 60s who display symptoms of dementia are still in work when they or a family member realise they have a problem. Sometimes mortgages still need paying, dependent family members rely upon this person and there is a real fear that a diagnosis will bring little gain and lots of loss. Young-onset dementia specific treatments, interventions, or support are a postcode lottery and are few and far between. So many services place younger people in with late-onset service users which is often inappropriate and doesn't engage or meet the needs of the younger person. Usually younger people with dementia don't present with the same co-morbidities as older people. Often we are physically fitter, have enormous amounts of physical energy - sometimes too much (!) and it's our cognitive functioning which lets us down, frustrates and at times leads to depression. Depression and dementia are a truly toxic partnership and having experienced both after a period of feeling "bullet-proof" it is sometimes difficult to know which is having a greater impact on my ability to feel that I am living well. I have drawn great support from professionals in KMPT, the Alzheimer's Society, Young Dementia UK, DEEP and Age UK which alongside my own reading, especially works such as those by Tom Kitwood, 'Still Alice' and 'Dancing With Dementia' have helped. For the past year the Alzheimer's Society have had Adrian Bradley in post as "National Lead - Younger People with Dementia" to champion and coordinate the Societies' provision for young people with dementia, and this again is a very positive innovation. Alongside this I serve on the National Network for Young Onset Dementia which has a range of agencies involved and is co-ordinated by Young Dementia UK (YDUK).

In the case of Kitwood I refer often to his illustration of a flower which has love at its centre surrounded by: attachment, comfort, identity, occupation and inclusion. When these are in place I live well.

Unfortunately there are times when as Kitwood describes: Malignant Social Psychology makes my life much more challenging. Aspects of this which negatively impact upon my self esteem and well being and result in fear replacing positivity. These are: treachery, disempowerment, infantilisation, intimidation, labelling, stigmatisation, outpacing, invalidation, banishment, objectification, ignoring, imposition, withholding, accusation, disruption, mockery and disparagement. I have experienced most of these in the past, especially in the past two years as subtle slips in my mental health have occurred.

The Royal College is acknowledging the needs of younger people with dementia, and sitting on the Royal College's Executive Board I am pleased to see that the need for age appropriate services to MSNAP standards are being introduced. This I am sure will help raise awareness amongst professionals and help provide better services for younger people with dementia.

I also am a member of the Alzheimer's Society Research Network and sit on their Grant Advisory Panel. We do receive applications for projects linked to care and wellbeing of younger people with dementia but not enough. One major relevant project the Society is funding is PREVENT which is receiving somewhere in the region of £600,000. Part of my role in the network is to help monitor this project. It is based in West London Mental Health NHS Trust and at Imperial College London and Edinburgh University and is focusing on people in their 40s and 50s. Its aims are: to find the very earliest signs of changes in the brain while we are still in good health, to propose prevention strategies and to monitor these strategies over time to evaluate their efficiency in slowing down the progression of biological changes in the brain.

To conclude, whilst neurologically there are many similarities between young-onset and late-onset dementia, the impact on the individual and their families and presentation of the condition are often very different. Consequently the type of treatments, interventions and support need to be person-centred, and fit for purpose in order that the person can live as well as possible for as long as possible.

Mr. Oliver has been supported in writing this article by Michael Blackburn, University of Kent, Psychology student on placement with KMPT.

## UK services for younger people living with dementia, Jo Rodda and Janet Carter.

**Havering Older Adults Community Mental Health Team and Memory Service, Victoria centre, Romford.**

Young Onset Dementia (YOD) generally refers to onset before the age of 65 years. Consensus international operational criteria are awaited but planned. There are key epidemiological differences compared to late onset disease with Alzheimer's disease accounting for a much smaller percentage of cases and genetic, rare and potentially reversible conditions more common. People with YOD make up 6-9% of the UK population who have dementia (Dementia UK update, Alzheimer's society 2014).

Despite smaller numbers, YOD causes a disproportionate burden on carers and care services. Provision of services to this group presents a unique challenge since the majority of dementia care remains focused upon the needs of older patients. Despite recommendations from the Royal College of Psychiatrists (College report 135, 2006) about Old Age Psychiatrists, 2006, taking a lead in service development and demand from patient groups for multidisciplinary specialist services, our impression was that there had been an erosion of Specialist multidisciplinary YOD services in the UK principally as a result of a move to ageless services.

In order to gain further information regarding the provision of services for diagnosis, management and aftercare of YOD we undertook an online survey of key UK professionals. Full results will be published separately, and the key findings and implications of the results are summarised in this article.

There were 250 respondents (including 189 consultant Old Age Psychiatrists), representing 76 NHS Trusts across the UK. In keeping with recommendations from the Royal College of Psychiatrists, older adult mental health services were the most likely to be responsible for diagnosis and ongoing care of Younger People living with Dementia (YPD) although widely divergent views were expressed in the comments section regarding care pathways. This made clear that diagnosis and ongoing care are sometimes provided by general adult mental health services; in some cases this likely represents chaotic care pathways, but in others it is explicit local policy.

15% of respondents reported that there was a contractual agreement for a service for YPD with the Clinical Commissioning Group (40% no, 45% unsure). 54% indicated that there was no access to a consultant with a special interest in YOD. Many commented that specialist YOD services had been absorbed into “ageless” generic Mental Health Services. Most psychiatrists did not have access to a forum for complex case discussions with non-psychiatry consultant colleagues.

25% of respondents reported access to age-specific post-diagnostic support for YPD and 28% reported no post diagnostic support at all. 13% reported that YPD had access to age-specific Cognitive Stimulation Therapy (CST), whilst 45% had access to generic CST; 43% reported that CST was not available to YPD.

Most respondents reported that younger people with dementia had no access to age-appropriate local respite (86%) or long-term (89%) care.

Despite the reports in the survey of chaotic care pathways and lack of age-appropriate services, 65% of respondents agreed with the statement that YPD receive a timely diagnosis. This is at odds with national data, which demonstrate that average time to diagnosis from symptom onset is approximately 4 years (van Vliet et al., 2013). Other results from the survey are more in line with patient views emphasising concerns about lack of knowledge and education of professionals, delays to diagnosis, the need for personalised psychological support, and the dearth of meaningful social or recreational activities and age-appropriate respite and long-term placements (Harris and Keady, 2004).

The Royal College of Psychiatrists service provision report for YPD (2006) had a number of lofty ideals, specifically recommending commissioned services for YOD, specialist multidisciplinary teams for services greater than 500,000 and 2 programmed activities for an Old Age psychiatrist to plan, develop and run a diagnostic and follow-up service.

Our survey demonstrates that far from these ideals, non-specialist Adult mental health teams are still sometimes responsible for diagnosis and management of YPD. There is a lack of widespread access to inter-specialty case discussion or a consultant with a special interest in YOD, and there are clinical, financial and geographical barriers to the goal of integrated care.

The results highlight serious concerns about the standard and consistency of care being delivered to YPD across the UK. Despite the increasing focus upon needs-led services, the available evidence suggests that, although there are pockets of excellence, this model of good practice is not currently reflected for YPD in the majority of services in the UK. The development of 'ageless' mental health services appears to have led to the disbanding of many specialist YOD services with a consequent loss of multidisciplinary expertise targeting the distinctive needs of YPD.

The essential elements of service provision for YPD, including clear pathways into care, availability of meaningful occupational and social activities, age-appropriate respite and long-term care and improved professional knowledge are well-established. The results of this survey serve to highlight the gap between this goal and current UK services.

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## Wielding the Geriatrician's Scalpel: Top Tips for Pharmacological Debridement, James Fisher.

**Specialist Registrar in Geriatric and General Internal Medicine (St7), Northumbria Healthcare NHS Foundation Trust, drjamesfisher@hotmail.com**

*In this article James Fisher explores, from the perspective of a trainee geriatrician, the challenging area of polypharmacy. What is it? Why does it matter? And what tips for managing it might old age psychiatrists be able to pick up from their colleagues in geriatric medicine?*

Polypharmacy, put simply, means too many medications. It sounds like a straightforward concept, but there has in fact been much debate about exactly how many medications ought to constitute too many. In recent years there is increasing recognition that simple numerical definitions may fail to appreciate that patients with multiple comorbidities may be taking multiple medications with valid reason. Consequently, definitions of polypharmacy that seek to pick a ‘magic number’ are perhaps falling out of favour – in place, the terms ‘appropriate’ and ‘inappropriate’ polypharmacy may be more clinically meaningful.

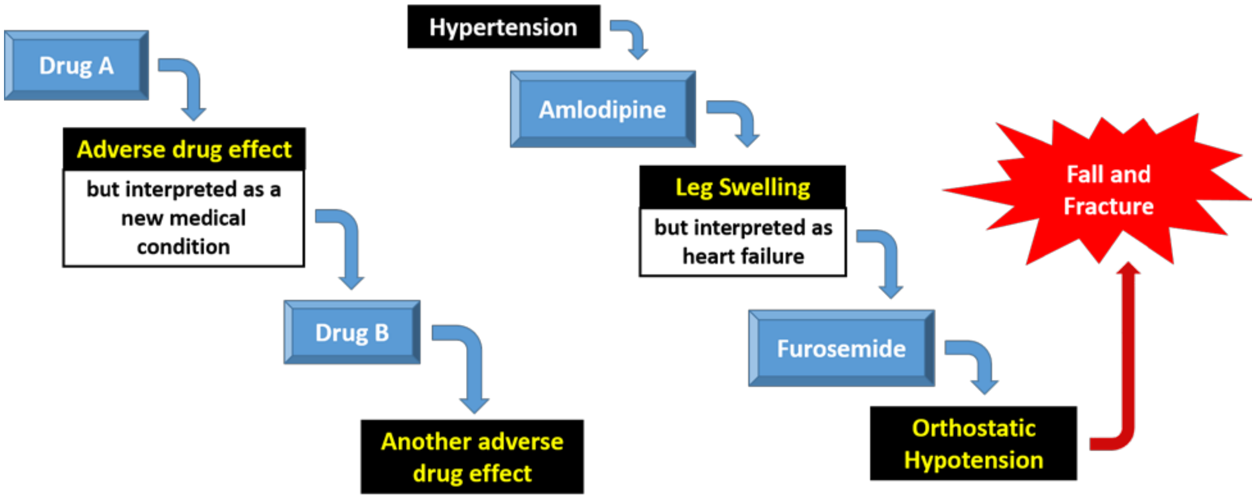
Polypharmacy matters. We know that the greater the number of medications a person takes, the greater the risk that they are subject to inappropriate prescribing. Furthermore, as the number of medications a person takes increases, so too does the risk of them experiencing an adverse drug reaction (ADR). The upshot of this may be an unplanned, emergency admission to hospital, with ADRs estimated to account for around 6.5% of UK admissions.

Recognition of inappropriate polypharmacy and optimisation of a person’s medication regime are considered core skills for a geriatrician. The process of optimising a person’s medications is sometimes referred to by geriatricians as de-prescribing or (perhaps with a nod to their surgical colleagues) as ‘pharmacological debridement’. Thus a geriatrician’s pen is their scalpel, which I won’t need to remind you, can be considered mightier than any sharp implement that a surgeon might wield. A thorough medication review forms a central component of comprehensive geriatric assessment (CGA), the evidence-based intervention on which the specialty of geriatric medicine is built.

Co-occurrence of physical and mental ill-health means that there is considerable overlap between the patient groups that geriatric medicine and old age psychiatry (OAP) care for. Within both groups there is high prevalence of multi-morbidity, frailty and polypharmacy. In the remainder of this article I hope to share some insights into the management of inappropriate polypharmacy from the perspective of a geriatrician. Patterns of inappropriate polypharmacy will be discussed, and consideration will be given as to how the challenge of managing inappropriate polypharmacy requires multi-disciplinary collaboration.

When older people living with frailty present to acute services, they invariably do so unexpectedly, and often do so with one of the classic ‘geriatric giants’: impairment of intellect (cerebral dysfunction), incontinence, immobility and/or instability (falls). One of the key messages when encountering such patients is to *always* ‘think drug’. A thorough medication review may unearth recent changes to a person’s medications - the addition of a new medication may well have been the factor that tipped the balance and resulted in the need for hospital-based care. There are a number of common prescribing pitfalls that geriatricians regularly encounter when undertaking medication reviews and an awareness of them may help you within your practice.

First, is the concept of the ‘prescribing cascade’, which is depicted in Figure 1 below. A prescribing cascade begins with the appropriate prescription of a drug for a particular medical complaint. Problems may arise if a patient encounters an ADR due to this new agent, since not infrequently there is failure to associate the development of a new symptom or sign as an ADR. Instead, the ADR may be interpreted as the development of a new medical condition. Further medication may then be prescribed for the supposed new condition, thus exposing the patient to the potential for further ADRs. The example shown in Figure 1b demonstrates a very commonly encountered prescribing cascade, which can ultimately result in morbidity.



*(a) Concept of a 'Prescribing Cascade'*   *(b) Worked Example of a 'Prescribing Cascade'*

**Figure 1: Prescribing Cascade**

Second, is the pattern of 'counter-productive' prescribing. Here drugs are concurrently prescribed that counteract the actions of one another. Two commonly seen examples, along with advice about how to proceed in such situations, are highlighted below:

- An anti-cholinesterase inhibitor and an anti-cholinergic (for treatment of continence problems) e.g. donepezil and oxybutynin
    - Has the patient undergone a thorough evaluation of their continence problems prior to pharmacological intervention? Anticholinergic agents may precipitate urinary retention and therefore the underlying cause for a person's incontinence must be established before their use.
- A loop diuretic and a synthetic mineralocorticoid (for treatment of orthostatic hypotension) e.g. furosemide and fludrocortisone
    - Could this also be an example of a prescribing cascade? Orthostatic hypotension could be as a consequence of the furosemide – is there a valid indication for the diuretic?

Thirdly, there are a number of 'common culprits'. These are drugs that induce a sharp intake of breath amongst geriatricians, since they are often implicated in the functional decline of older people. Examples of these drugs, including the problems they cause and management strategies to consider employing, are displayed in Table 1 below:

***Table 1: Common culprits***

| **Category** | **Examples** | **Use(s)** | **Problem(s)** | **Suggestion** |
|---|---|---|---|---|
| Alpha Blockers | Doxazosin | Resistant Hypertension | Falls (due to orthostatic hypotension) | Ensure lying and standing blood pressures are checked. Consider ambulatory blood pressure monitoring to confirm diagnosis of hypertension |
| | Tamsulosin | Prostatic Hypertrophy | | |
| Non-steroidal anti-inflammatories (NSAIDs) | Ibuprofen | Analgesia | Gastrointestinal bleeds, renal dysfunction | Use with caution: short courses only (1-2 weeks) and consider concurrent use of proton pump inhibitors |
| | Diclofenac | | | |
| Benzodiazepines | Nitrazepam | Hypnotic, | Sedation and | Avoid rapid withdrawal. Flag to |

| | | | | |
|---|---|---|---|---|
| | Diazepam | Anxiolytic | falls | general practitioners the need to cautiously rationalise |

Fourthly, it is vital that clinicians appreciate that optimising complex medication regimes requires complex, multi-faceted interventions. It may not be possible to remedy inappropriate polypharmacy within one clinical encounter, or even during one hospital admission – the process is often iterative, and reliant on 'buy-in' from a variety of other stakeholders. Team-working with other health professionals is essential: liaison with other hospital-based specialties is often required to establish whether a particular drug can be safely discontinued; general practitioners have a central role in supervision of coordinated reductions in medications on an out-patient basis. One simple way to bring the problem into the consciousness of health professional colleagues is to include polypharmacy within the problem list / diagnosis list within a patient's health records.

The role of junior doctors in the process of managing polypharmacy should not be neglected. Almost every patient admitted to hospital will have a medication chart, or its electronic equivalent, completed by a junior doctor. This process of transcribing medications onto a medication chart is often perceived by junior doctors as a 'chore' or a 'paper exercise', when in fact it offers an ideal opportunity to screen for inappropriate polypharmacy. Clinicians need to try and empower junior doctors, through teaching about polypharmacy, to be on their guard for the prescribing pitfalls commonly seen in older patients. To drive this change, we need to try and reframe the task as an active process, where junior doctors can add value to a patient's care, rather than simply 'form-filling'.

Junior doctors also have an essential role to play when patients leave hospital. The communication of any medication changes (and the rationale for these changes) between secondary and primary care is a vital stage in the management of polypharmacy. As with medication charts, the job of competing discharge summaries typically lies with junior doctors, and is also often viewed negatively. The importance and clinical relevance of discharge summaries needs to be highlighted for junior colleagues through constructive means, and may be a ripe area for quality improvement projects.

Lastly, there is merit in considering management of polypharmacy from the patient's perspective. The burden of taking multiple tablets, multiple times a day, for prolonged periods, cannot be underestimated. If a patient encounters a hospital-based specialist (who may be unfamiliar to them) and is told to discontinue a tablet they have taken for many years, they may understandably have reservations about doing so. Effective communication is therefore essential - clinicians should reflect on how they undertake such discussions, and how they might improve this process. Clearly there is no 'one-size-fits-all' approach to what is a complex art, but compare "you don't need that tablet anymore" with "over time your body changes but the tablet stays the same".

In conclusion, polypharmacy in older patients is a major problem:

- To adequately address it, clinicians need to be able to spot inappropriate polypharmacy. Doing so requires awareness of prescribing cascades, counterproductive prescribing and the 'common culprits' in older patients.
- Senior clinicians have a key role in increasing awareness of polypharmacy amongst the healthcare team, through inclusion of the term in problem lists, handovers and discharge letters.

- Senior clinicians also have an important role in terms of demonstrating good practice to their junior colleagues, by taking a pro-active approach to polypharmacy and through role-modelling of effective communication.
- Solving polypharmacy often requires a coordinated team approach, needing buy-in from junior doctors, assistance from pharmacy colleagues and support from fellow specialist colleagues.

## Immediate post diagnostic support in dementia – can we optimise our practise? Dr Sujoy Mukherjee and Ruth Evans

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### Introduction

Dementia has received unprecedented attention in recent years as a major medical, social and economic challenge globally and the UK is no exception. One key focus here has been low rate of diagnosis which was highlighted by the Alzheimer's Society report and prompted Prime Minister's Challenge to increase the rate of diagnosis to at least two third of the estimated total number by March 2015. This milestone has now been achieved in London and the number is increasing steadily.

While this is a very welcome development and benefits of a timely diagnosis are well documented, the impact of this challenge to Old Age Psychiatry services cannot be underestimated as old age psychiatrists remain the key professionals to diagnose and manage dementia in the UK. From a patient and carer's point of view, diagnosis is often a pivotal point and the beginning of a new and often stressful journey.

While there has been a huge focus on the number of diagnosis of dementia from the government and all interested parties, one real challenge remains; to develop and maintain a high clinical standard of the diagnostic encounter as this is the beginning for the patient and their carer to live well with dementia.

### Development of the guideline

London Dementia Strategic Clinical Network (SCN) in London offers clinical leadership and advices to support London's dementia services so that people with dementia receive a good-quality diagnosis, have access to high-quality treatment and are cared for with dignity and respect. The SCN is led by a group of expert clinicians, social care professionals and representatives from the voluntary sector. The network currently has four key workstreams, effective diagnosis, post diagnosis support, improving quality of care and the acute leads network.

We identified immediate post diagnostic care as a priority and set up a multidisciplinary work stream involving health, social care and voluntary sector. The report, "Immediate Post Diagnosis Support Guidance" has been well received by the executive committee of the Faculty of Old Age Psychiatrists (Royal College) and commissioners network in London.

**Key points**

1. We believe the diagnosis of dementia should be overseen by a senior doctor with appropriate knowledge and expertise in most cases. Currently this is often done in a memory clinic setting following an assessment. However, that crucial interaction and immediate aftercare planning needs to address much more than just handing over a diagnosis.
2. The guideline is flexible and can be adapted to a local service delivery model.
3. Very often in our clinics we are asked "Is it dementia or Alzheimer's*?", therefore*, it is so important to explain the diagnosis and what it means. A discussion on progression is often appropriate, even if to highlight the uncertainty of the prognosis.
4. People often equate dementia with only memory problems. This is the time to talk about all what we mean by global cognitive impairment, functional impairment and behavioural and psychological symptoms, both current and anticipated.
5. Prescriptions of NICE approved dementia treatment (Cholinesterase inhibitors and Memantine) have increased six fold between 2004 and 2014 (Focus on Dementia, January , 2016, Health & Social Care Information Centre) . A careful consideration of any contraindication, caution or drug interaction prior to initiation of treatment, as well as discussion of expectations and monitoring arrangements with patient and/or their carer provides a good start.
6. Carers' needs assessments and appropriate support plans are as crucial as the treatment plan for patient. The Care Act 2014 makes these needs assessments mandatory and is therefore an important read for all clinicians.
7. Signposting both the patient and carer to resources available beyond one's own service is a crucial element of good post- diagnostic care. One key benefit of increasing awareness of the benefits of diagnosis is that people are now being diagnosed relatively early and retaining more cognitive and functional ability at the time of diagnosis. This gives us an opportunity to maximise their ability and potential, so we need to choose signposting carefully. We, as clinicians, need to be well aware of local resources but also exploratory in our thinking. It is also key to manage the risks that we may have identified.
8. We, psychiatrists, are also physicians. So, it is crucial for us to be focussed on physical co-morbidities and secondary prevention advice. A focus on vascular risk factors (control of diabetes, hypertension, hyperlipidaemia etc), advice on diet, exercise, importance of compliance and regular health check up are crucial to optimise the care of many of our patients.
9. Delirium is a common complication of dementia and often a delay in the diagnosis results in expensive and unnecessary hospital admissions with multiple adverse outcomes. We should use this opportunity to discuss the risk of delirium with the carers and make them understand the common symptoms and what to do it is suspected.
10. Patients and carers should be given simple advice on financial planning and where to go for further information where appropriate, i.e, Lasting Power of Attorney or making a will.

11. Patient and carers should be informed about opportunities to participate in research, locally or elsewhere. Currently less than 4% people with dementia participate in research nationally (Department of Health, 2012) but the Prime Minister's Challenge sets the target at 10%. Without active involvement from clinicians this target is unlikely to be achieved.
12. Advanced care planning and end of life care remains a difficult area to approach, particularly at the time of diagnosis. This area is evolving and we need to develop a good understanding and an agreed approach to this delicate issue. It is important that patients and carers are given the opportunity to plan ahead if they would like to, this is especially important whilst the patient still has capacity.
13. A diagnosis of dementia is often stressful for the patient and the carer and whilst a lot of information is helpful, it could be overwhelming in one sitting. So, a post diagnostic meeting is crucial in whatever locally agreed form to give an opportunity to clarify issues and consolidate the care plan.

## Conclusion

Maintaining the quality of the diagnostic process and immediate post diagnostic care is a huge challenge because of increasing numbers of referrals and often limited resources. However, in the debate over quality versus quantity, sometimes it is best to have both. It is crucial that as the diagnosis rate increases, we are able to offer patient and carers a good-quality diagnosis and access to post diagnosis support. We hope that our guideline helps commissioners and clinicians to develop and maintain quality in this aspect of dementia care. Although this work has been produced in London, the findings and recommendations are equally applicable elsewhere in the country.

**Acknowledgement**: We are grateful to Dr Daniel Harwood, Director of London Dementia Strategic Clinical Network and members of the work stream " Immediate Post Diagnostic Care" for their valuable contribution.

## Further reading:

1. http://www.londonscn.nhs.uk/publication/dementia-immediate-post-diagnosis-support-guidance/
2. https://www.carers.org/sites/default/files/care_act_briefing_june_2014.pdf
3. Prime Minister's challenge on Dementia 2020, Department of Health

## Assessing Mental Capacity and Deprivation of Liberty Safeguards (DoLS), Chris Pearson and Alison Reeve.

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The law and the application of assessing mental capacity are set out in the MCA 2005 and the MCA Code of Practice. In Deprivation of Liberty Safeguards in particular, there is a process to be followed but it can be misinterpreted, that's all it is, a process. Assessment of a person's mental capacity under DoLS is more than a process to be followed, it has to take into account the totality of the person and predominantly this means taking into account a subjective component, namely; 'what would the person have done if she had the capacity?' This component is more particularly enshrined within the role of the assessor for best interest, the ability within that role to put ourselves in a person's shoes and trying to make the decision she would have made. This is why there is a clear interrelationship between the DoLS assessment of mental capacity and the assessment of best interest. Both assessments need to be clear about the concrete details of the material decision that needs to be assessed and the choices facing the individual. Challenges in the Courts under Article 5 rights too often show that this is the crucial area that assessors do not consider in sufficient depth or give sufficient weight in empowering concrete choices to be made about the specific decision. This article aims to explore this further by setting out the essential elements that need to be taken into account in the assessment of mental capacity under DoLS and ensuring it is clearly person centred to the material decision to be made.

In Wales, a Supervisory Body commissions the Mental Capacity Assessment from either a Best Interest Assessor (BIA) or from a Section 12 (2) Approved Doctor, dependent upon the Supervisory Body area. There are key aspects that are central to the assessment of capacity;

## 1. Presumption of Capacity and Decision to be Made:

This is an important aspect of the mental capacity assessment that it is enshrined within the Mental Capacity Act(MCA) 2005 as one of the statutory principles.[i] The fact a person has a diagnosis advanced dementia does not affect the presumption of capacity, the burden and standard of proof lies with the assessor on the 'balance of probabilities [ii] and relates to a particular decision at a material time.[iii] This proof must involve the assessor committing in writing their assessment how they have come to the conclusion the person lacks capacity in relation to the specific decision. This may seem an obvious statement to make but the correlation between lacking capacity and the specific decision is not always clear in practice. This is highlighted in a number of landmark cases (e.g.: CC v KK [2012][iv]). For example, if an application has been made for a DoLS within a hospital setting, the material decision to be made is about whether or not the individual should be accommodated in this particular hospital for the purposes of being given specific care and treatment. So it is crucial that those who are tasked with undertaking a mental capacity assessment under DoLS, are clear that in this instance, they are not being asked to assess a decision about discharge home or being accommodated in a care home, that is an entirely different decision and would involve a different decision maker (i.e. the Local Authority).

## 2. Functional and Diagnostic test:

The decision of the Court of Appeal in PC v City of York Council[v] in our view rightly reversed the order of the 'diagnostic' and 'functional' test as set out in MCA 2005, s.2(1) as it helps to centre upon what is reflected in practice; namely the critical focus should be on the decision to be made and "is the person's inability to make specific decisions at the time when it needs to be made *because of* the impairment of, or disturbance in the functioning of, their mind or brain?"

In practice of course, the process is not changed and the focus of the mental capacity assessor has to be about being satisfied which of the four functions; **understand,** r**etain**, **use** and **weigh it up** and then to **communicate** by any means possible that decision. If this has any meaningful rationale it must be about enabling the individual to partake in these steps 'which reflects the person's individual circumstances and meets their particular needs."[vi]

The assessment has to be conducive to creating an opportunity to enable the individual to express their wishes and feelings about the decision in a way that minimises stress and anxiety. For instance there may be an issue of understanding or weighing up or recall due to poor short-term memory. Concentrating the assessment on examining the extent of short term memory may immediately raise anxiety because the individual struggles to fill in the gaps and so become more defensive and that impacts on their engagement and communication. Account needs to be taken that assessment of capacity is not about establishing de facto short term memory loss but how to better engage with the individual. To enable the individual to feel less anxious and support them to absorb the information to enable them to communicate their views regarding the decision to be made.

Assessment of capacity is not something that can be carried out in a few minutes and nor is it about the medical condition itself. It's more about trying to get the individual to tell their unique story of important life events and the relevance to the decision to be made. Assessors need to constantly remind themselves of the Code of Practice, in particular Chapters 3 and 4, which gives excellent guidance on optimising interviewing an individual's capacity. We would further recommend referring to pointers set out by A. Keene in his book, 'Assessment of Mental Capacity, 2015'[vii] which sets out practical ways to create the right environment for assessing capacity. In addition it is important to note that it is not necessary for an individual to understand every aspect but rather to understand in general terms information relevant to the decision[viii].

### 3. Assessment and Options:

A critical aspect of the BIA and s12 (2) Doctor in their assessment is to document and record their assessment in a in a clear and concise way and evidence their assertions so that it is transparent and open to scrutiny by the Supervisory Body. Sometimes that may be scrutinised and examined by the Courts, so writing an assessment with this in mind is not a bad idea.

If a decision is to be made about deprivation of liberty safeguards in a hospital or care home setting, we would contend that the mental capacity assessment should make discernable reference to the various options available and balanced against the risk and benefits to the individual; the likelihood of those risks and benefits occurring; what is in essence referred to as a balanced option approach, a format well evidenced in the Courts. This format is specifically relates to the Best Interest Assessment but is not confined to this assessment alone. The need to define the benefits and risks to the mental capacity assessment is also vitally important. If the s12(2) Doctor has been commissioned to undertake a mental capacity assessment then it becomes even more vital that conclusions are shared with the BIA and vice versa. This is how we can learn and develop practice by sharing our knowledge, skills and experience in an area that is complex, challenging but essentially rewarding and most importantly is for the benefit of the individual whom we are assessing.

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**References**

[i] MCA 2005, s.1(2).

[ii] MCA 2005, s.2(4).

[iii] MCA 2005, s.2(1)

[iv] CC v KK [2012] EWHC 2136 (COP) (Baker. J)

[v] PC v City of York Council v C [2013] EWCA Civ 478; [2014] Fam 10.

[vi] MCA 2005, Code of Practice, Chapter 3.

[vii] Keene. R. (2015) Assessment of Mental Capacity, A Practical Guide for Doctors and Lawyers, pgs 17-19, 4th Edition, Law Society Publishing.

[viii] CC v KK [2012] EWHC 2136

## Old Age Faculty response to Law Commission (LC) consultation about DoLS: Dr Gianetta Rands.

In November 2015, our Faculty sent 4 documents to the LC in reply to consultation paper CP222 regarding changes to Mental Capacity and Deprivation of Liberty (DoL) legislation.

These were:
- summary of comments from the Faculty of Old Age Psychiatrists
- an appendix answering LC specific questions
- Dave Jolley "DoLS - introduced with good intentions, but has it now become a poisonous chalice for England and Wales?" Old Age Psychiatrist (2015) 62.
- Dave Jolley's Impact Assessment.

These were distributed to all Faculty members for reference. Our comments were organized per CP222 chapter.

**Ch1: Introduction and Background.**

We agreed that current DoLS legislation is not fit for purpose and that Cheshire West Supreme Court judgment of 2014 extended the remit of DoLS in ways that make this legislation unworkable, overwhelmingly expensive and conflicting with the original principles of the Mental Capacity Act 2005 (MCA).

We noted that people detained under DoLS are detained by the state and thus their deaths require referral to the Coroners Court.

We supported the LC view that Article 8, Human Rights Act needed more prominence in any new legislation in particular the right to respect for private and family life including home and correspondence and the right to expect personal information to be confidential (this may not be respected by the current system or the new proposals).

At this point we referred to the 5 basic principles of the MCA:

1. A person must be assumed to have capacity unless it is established that they lack capacity (assumption of capacity)
2. a person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success (maximising decision making capacity)

3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests (doctrine of best interests)
5. An act done, or decision made, must be the less restrictive option in terms of the person's rights and freedom (least restrictive option)

**Ch2: Analysis of the Deprivation of Liberty Safeguards.**

We agreed with their analyses that current DoLS legislation should be scrapped. We agreed that an easy access/informal tribunal style process was needed and that new legislation should be straight forward and accessible.

With regards to an impact assessment we estimated that the proposed legislation could apply to approximately 2 million people at any one time (including those with temporary and reversible mental incapacity due to physical or mental illnesses).

**Ch 3: Principles of Protective Care.**

We agreed the importance of maintaining the ethos and principles of MCA and Article 8. Our priorities for the new system are that is should be simple and accessible, have a rapid appeals system and not compromise treatments or care.

**Ch 4: The Scope of the New Scheme.**

We agreed that the scope of protective care should include hospital, care home, supported living, shared lives and domestic accommodation.

We wondered about the appropriateness of invoking Article 5 when people are acutely unwell with temporary and reversible lack of mental capacity i.e. acute confusional states.

A deprivation of liberty must be imputed to the state in order to engage article 5; we wondered to what extent this covered hospital and other medical treatments and circumstances in which there is a temporary lack of mental capacity.

We suggested that acknowledgement is needed that mental and physical illnesses can impair mental capacity and that medical treatment and care are priority rather than restrictions or deprivations. If a time period is needed 90 days rather than 28 days more accurately reflects recovery from conditions that can cause acute and temporary confusion. We agreed that the care plan is the key to best protective care.

**Ch 5 Overview of Protective Care (PC).**

We noted that this new scheme is firmly rooted in the MCA, and suggested that reference to reversible mental incapacity and steps to delay or facilitate decision making should be included i.e respect Basic Principle 2, MCA.

The PC scheme would consist of:

(1) supportive care (SC) – would apply to people in care homes, supported living and shared lives accommodation;
(2) restrictive care (RC) and treatment scheme – would apply to people receiving restrictive care and treatment in care homes, supported living and shared lives accommodation (and to deprivations of liberty involving people living in family and other domestic settings)
(3) a hospital scheme – would also cover, in some cases, palliative care.

We were concerned that these definitions were not robust or clear enough but we preferred the terms SC and RC to "Deprivation of Liberty".

**Ch 6 – Supportive Care.**

The fundamental point of chapter 6 is that supportive care will apply to everyone who lacks capacity. The proposals would apply to over 1 million people who have enduring mental incapacity and require long-term treatment and care; a further million could be included due to reversible mental incapacity due to physical and/or mental illnesses.

We emphasized the need for confidentiality, dignity and respect of personal information and that this be prioritized when monitoring these systems.

The introduction of Approved Mental Capacity Professionals (AMCPs) and informal Advocates for this group of people could be extremely expensive without clear benefit to those lacking capacity.

We advised the LC to think about when a relative or family member will be used to guide decision making and when expensive IMCPs might be used.

The effective application of s5, MCA could cover all that is proposed under supportive care. If further clarity is needed a Decision Documenting Form could suffice.

We agreed that people who lack mental capacity should have Care Plans that are regularly reviewed e.g. 6-12 monthly and include details of their capacity assessments and best interests' decisions. These should be confidential documents.

We supported the introduction of a local and accessible Appeals process to supplement proper use of s5, MCA and think that this would contribute to its effective implementation.

The rights of self funders who lack capacity are covered by s5, MCA when used in the context of decision making and best interests.

We pointed out that the level of demand could overwhelm heath, social and legal services.

**Ch7: Restrictive Care and Treatment**.

The LC sets this out as the replacement for DoLS but the remit of RC is wider than the current DoLS and will affect more people than are currently covered by the Cheshire West ruling. For every one of these, the LC recommends a formal process with second opinion doctor and an AMCP.

The wide ranging recommendation that the Court of Protection (CoP) be used to authorise placements will send so many people to the CoP that Article 3 of the Human Rights Act could be breached (right to a fair and timely trial)

We thought that Article 8 of Human Rights Act is breached because the new law interferes with family and private life and imposes a universal need for an AMCP and others to be given a wide range of confidential information. That breaches the right to privacy.

The group of people referred to need Complex Care and Complex Treatment and Care Plans. Using this sort of terminology is equivalent to that used for people with mental capacity, is consistent with a care model, and less stigmatizing. We wondered whether covert medications should be considered here.

**Ch 8: Protective care in hospitals and palliative care.**

The LC proposes that the hospital system be based on Deprivation of liberty and not Restrictive Care. They focus on not free to leave as the acid test of imposed care.

When people are ill, physically or mentally or both, their mental capacity may be variable. In keeping with the principles of the MCA decision making and consent issues should be addressed when that person is optimally capacitous. A patient could give consent for restrictive treatment that may be needed when they next lack capacity.

Most hospitals already have a system of responsible consultants and written multidisciplinary care plans. We suggest that 90 days is more realistic in terms of time taken to fully recover capacity after an episode of acute confusion, whatever the cause.

### Ch 9: Advocacy.

The proposal that all people subject to RC should have an independent advocate is unworkable. Formal advocacy should not be the default position. There will need to be local mechanisms for displacing those with suspected malevolent intent.

### Ch 10: Mental Health Units and the Mental Health Act.

Many colleagues are worried by the proposal that only the MHA be used in dementia assessment units. The MCA legally covers decision making processes for people who lack mental capacity. We are mindful of the case of SLAM vs AM where it was held that AM had the right to be treated under the MCA even though the MHA might have been used. The MHA covers assessment and treatment of mental illnesses only and not physical care. Therefore, especially in frail elderly Mental Health units the MCA will still be needed for the majority of care and treatment.

We are concerned that the current situation and the relative lack of understanding of the MCA, means that the MHA is being excessively used e.g. s135 to transfer people with dementia from hospital to care home, or s2 to admit people with acute confusion due to physical illnesses to general hospitals.

### Ch 11: Right to appeal.

We agreed that a robust local tribunal system, modelled on the MHA, is sensible but we advised against meddling with MHA systems which work well and are established.

### Ch 12 – Supported Decision making and Best Interests.

We think that in most cases a “supporter” should be the person who acts as an advocate, such as a family member. A mechanism to displace advocate/supporter is required if they consistently fail to make best interests decisions. We think that MCA s4 and s5 cover most decision making and best interest requirements.

### Ch 13: Advance decision making.

We support the view that advance refusals have not worked well, and comment that changing and unpredicted needs have made the legally binding nature of ADRTs complex. We support the suggestion for a broader system of advance statements that should be confidential and kept as confidential medical records.

### Ch14 - Regulation and monitoring.

We are concerned that many aspects of the current proposals risk wide distribution of highly confidential medical and personal information. A regulatory system similar to a SOAD system might be appropriate.

### Ch15 – Other Issues.

Using the same age ranges as MCA seemed reasonable if consistent with other statutory processes such as Gillick competence, Caldicott guardians, and Children's Act.

The issue of coroners inquests into the deaths of people under DoLS is already a serious difficulty that has caused great distress to many families following natural and timely deaths of their relatives. We suggested that inquests should be reserved for cases where there are concerns about care.

Many of our colleagues take the view that people who are terminally ill with dementia should not be charged for nursing home care. The current use of section 3, MHA has achieved this as s117 aftercare is provided indefinitely for people with dementia.

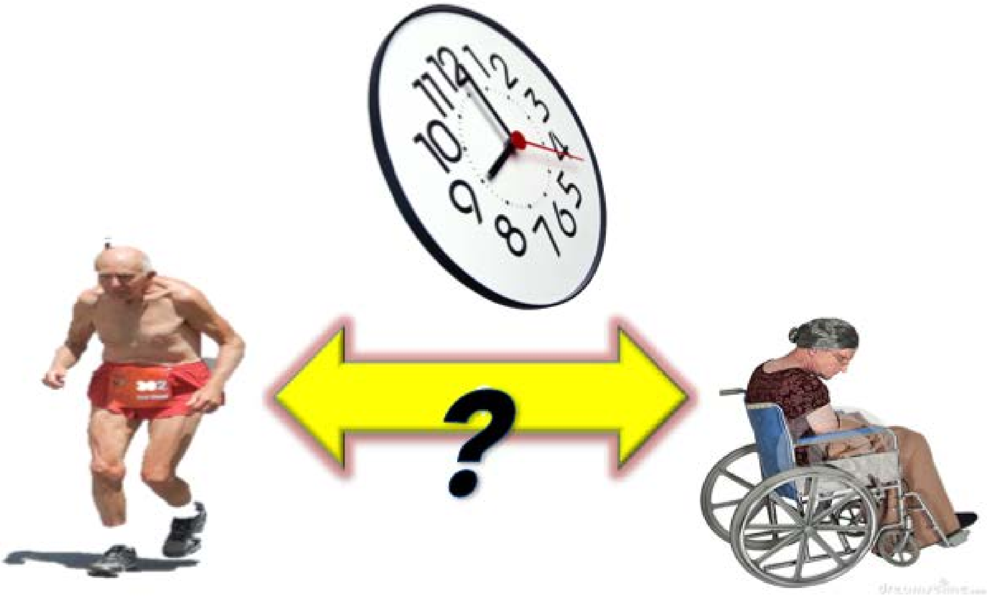
A final point is about the costs of these new proposals which will be great even excluding the costs of clinical time needed for their implementation.

In summary, we agreed with CP222 that DoLS was not fit for purpose and should be scrapped. We thought the proposals for protective care comprising supportive, restrictive and hospital care were over-intrusive, expensive and unworkable. We repeatedly referred back to the MCA(2005) and The Human Rights Act.

## Why should policy makers be interested in the demography of ageing? Dr Noel Collins,

## Consultant Older Adult Psychiatrist, Surrey and Borders NHS Foundation Trust

## (Part 2)



In a series of 3 essays, I am examining why policy makers should be interested in the demography of ageing and the challenges that these will create for the delivery of future health and long term care in the UK. In my first essay (Collins, 2015), I looked at mortality trends, rising life expectancy and the rise of the 'oldest old' and whether heath care rationing is an appropriate response to this trend. In the second of the three essays, I will examine several morbidity projections in older adults and how each scenario presents differing challenges for health and social care policy makers.

Although it is clear that the UK's older population is growing, it is less certain how healthy this group will be. Unfortunately for health policy makers, projections for morbidity-mortality linkages vary**.** Gruenberg suggests that healthy life expectancy (HLE) is not rising as quickly as life expectancy (LE) and this will result in a *pandemic of chronic disease* as the population ages and the gap between HLE and LE widens (Gruenberg, 1977). An alternative view from Fries is that HLE will approximate LE resulting in a *compression of morbidity* (Fries, 1980) . On the other hand, Manton predicts an ongoing increase in LE but with a *dynamic equilibrium* between healthy and unhealthy populations within this (Manton et al., 1991). Each projection has profound implications for the health care policy for older adults. Should the focus be on caring for a disabled, frail elderly population with an increasing burden of chronic disease? Or should policy be focused on maintaining a healthy older population that only experiences real morbidity before death (Breyer and Felder, 2006)? Or will policy need to accommodate a heterogeneous population of individuals on different health trajectories?

### Gruenberg and the pandemic of chronic disease scenario.

The Gruenberg model of morbidity-mortality linkage represents the nightmare scenario for health policy makers. He argues that the success of modern society to lengthen life has come with a failure to control an exponential rise in chronic diseases such as dementia, diabetes and schizophrenia (Gruenberg, 1977). Increases in the prevalence of these three conditions alone in the over 65 population would create enormous pressure on future NHS budgets (Hex et al., 2012, Knapp, 1997, Lowin et al., 2001) as long term conditions already consume 70% of the total NHS budget (England, 2014). How can policy makers respond to the Gruenberg threat of *pandemic of chronic disease*? Although maintaining the current configuration of the NHS and social care is an option (Spicker, 2004), most health commentators agree that a new health strategy is now needed (Productivity Commission, 2005).

NHS England recently released its *NHS Five Year Forward View.* This vision argues that the NHS is not currently configured to deal with chronic disease, due to a legacy of its original focus on acute illness (NHS England, 2014) and the current divisions of primary and secondary care. Current market-oriented reforms in the NHS and the increasing commodification of disease may fragment care further as chronic disease care pathways may be avoided by some providers in preference for more profitable and simpler acute disease services. (Matsaganis and Glennerster, 1994).

Strategy has long been the favoured governmental policy response to the threat of increasing morbidity in the older population. An example is the DH dementia strategy, launched in 2009, which aimed to improve the awareness, diagnosis and the care experience of dementia through 17 key objectives. However, the strategy was launched without any additional funding and therefore has not been successfully implemented everywhere (Department of Health, 2004). Other difficulties have included GP scepticism regarding the benefits of early diagnosis (Ahmad et al., 2010), questionable evidence regarding the available interventions (Greaves and Jolley, 2010), lack of resources in primary care (Koch and Iliffe, 2010) and the resistance by the public to the intrusiveness of the biomedical model (Milne, 2010). Other policy options to the threat of a rapid expansion of chronic disease in a rising older population include disease self management through promotion of the 'expert patient model' (Donaldson, 2003). More broadly, the international experience suggests that universal coverage benefits people with chronic disease (Schoen et al., 2009) and that it may better managed within primary care rather than being outsourced to private health care providers (Bodenheimer, 2000) . Gruenberg argues that more research is urgently needed into chronic disease in later life to prevent an epidemiological time bomb (Gruenberg, 1977).

**Fries and the postponement of chronic disease.**

In contrast to Gruenberg, Fries believes that chronic illness can be postponed by changes in life style. He argues that 'if this postponement is greater than increases in life expectancy, then average cumulative lifetime morbidity will decrease' (Fries, 2005) (p. 131). This suggests that health policy makers could focus much more on promoting healthier lifestyles in midlife to increase the chances of a healthier later life (Vita et al., 1998). This may in turn increase the participation of older people in the labour force (Jagger et al., 2009) and society (Doyle et al., 2009) and stabilize health care spending among the elderly (Lubitz et al., 2003). Unfortunately, NHS attempts at health promotion have generally failed and without ring fenced funding for this, any future endeavour may be dampened. It may be that broader policy endeavours such as plain tobacco packaging (Moodie et al., 2012), a sugar tax, minimum unit pricing of alcohol (Stockwell, 2014) and incentivizing weight loss (Paul-Ebhohimhen and Avenell, 2008) may be more effective. However, all of these proposals have met with both industry and public resistance on grounds of personal responsibility and choice (Minkler, 1999).

**Reducing the cost of death.**

It is observed that the high health costs observed in older age groups may be due to health consumption in the last year of life (Seshamani and Gray, 2004). If this sharp escalation in costs prior to death can be further understood, then disproportionate health care costs in the oldest old may be reducible. Policy makers could begin with funding more research into the trajectories of dying (Fassbender et al., 2009) and stimulation of public debate on the increasing medicalization of a normal event in life - death (Clark, 2002). Baltes and Smith suggest that the current disproportionate focus on extending life at all costs reduces 'the opportunities of increasing the number of people to live and die in dignity' (Baltes and Smith, 2003)(p 123). Better palliative care may be the way forward, but its application is limited by the unpredictability of death as an event (Coventry et al., 2005).

**Manton and the dynamic equilibrium of health and morbidity.**

Like Fries, Manton predicts increasing in LE but with a dynamic equilibrium between healthy and unhealthy populations within this (Manton et al., 1991). This implies that the health system in the future will need to be flexible to meet the health needs of an increasing heterogeneous older population. However, although morbidity is being delayed for most individuals, the prevalence of chronic diseases continues to rise (Parker and Thorslund, 2007) and whilst some gains have been made in some lifestyle risk factors such as smoking and exercise, other risk factors such as obesity are increasing (Lubitz et al., 2003). Policy makers will need to address these divergent trends and be more responsive to different demand scenarios. However, demographics have limitations in informing overall health strategy as population based prevalences do not reflect average life trajectories (Parker and Thorslund, 2007) which can vary greatly even in the disabled and frail groups (Zimmer et al., 2012).

In my final essay, I will discuss how social care policy may need to change to meet the needs of an ageing population. I will also look at the economic rhetoric of the ‘population ageing time bomb’ and how opportunities associated with an ageing population are generally overlooked by policy makers.

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## The End of Formal Social Health Care - A provocation by International Longevity Centre-UK (ILC-UK), Dr Rupali Guleria and Dr Martin Curtice.

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The End of Formal Social Health Care - A provocation by ILC-UK' (ILC-UK 2015) is the second report from The Centre for Later Life Funding (a coalition of organisations and individuals seeking to improve on the Care Act 2014's recognition for the need for financial advice). The Centre is part of the International Longevity Centre – UK (ILC – UK) which is a think-tank impacting policy on longevity, ageing and population change. The report considers the future of adult social care, looking closely at the current state of social care in light of an increasing ageing population and a predicted care funding crisis. It provides an in depth analysis of the proposed measures outlined in the Government's Spending Review 2015 (presented to Parliament in July 2015 by the Chancellor of the Exchequer to the Treasury) and their actual impact in terms of raising additional funding and actual spending on adult social care. The report pulls no punches – it argues the proposed measures outlined within the Spending Review will not be sufficient to meet the growing care needs of an ageing population. It further suggests such measures are 'likely' to result in polarisation of care and specifically private formal care for those that can afford it, rising reliance on informal carers and increasing unmet needs for those that can't. The report surmises that with local government facing more real terms spending cuts it is unlikely that we have the required infrastructure to move to a model of care that relies so heavily on family and community support. This article brings out the salient issues from a very interesting and indeed provocative report that will be of interest to those involved in the care of older people.

**Introduction.**

With an increasingly ageing population, a greater proportion of public expenditure will be needed for services used by older people. The report noted that in 1997-8 33.8% of government expenditure was directed at the health service and older people and that this was set to rise to 42.3% in 2020. However, the report describes adult social care funding as 'woefully' underfunded, in comparison to healthcare (the report describes adult social care as being 'the misunderstood sibling of healthcare'). Social care is means tested and hence not necessarily always free at point of delivery, unlike the NHS. Adult social care, in addition, is funded by the local government and not the global budget. As governments have made cuts to spending on local governments, it has had a knock on effect resulting in reduced spending on adult social care. In the last parliament, the government agreed to implement the 'Dilnot Reforms' which would result in a more generous means test and a cap on care costs, but this has been delayed until 2020 with concerns that it might even be scrapped (the Dilnot reforms are recommendations made in 2011 by the Commission on Funding of Care and Support and was chaired by Andrew Dilnot; these recommendations were part of a blueprint for reforming social care funding).

In light of the above, in the 2015 Spending Review, the Chancellor announced further funding for the adult social care sector. The report opines that this spending review marks a 'critical moment for the future of adult social care'. Some of the plans include:

1. **Council Tax precept** – councils will be enabled to be able to raise their council tax by 2% explicitly to raise funds for social care.
2. **Better Care Fund** – there will be a £1.5billion increase in the Better Care Fund (this £5.3billion fund was announced by the government in 2013 to ensure a transformation in integrated health and social care by creating a single pooled budget to incentivise the NHS and local government to work together more closely).

3. **An extra £3.5billion?** – the government anticipates these measures may potentially lead to an additional £3.5billion being available for adult social care provision by the end of this Parliament.
4. **Dilnot Reforms delayed not cancelled** – the government has reiterated its commitment to bring these reforms in by 2020 (specifically saying they have been postponed but not cancelled).

   In light of these proposals the report asks three pertinent questions:

   1. Is there a future for formal adult social care?
   2. If there is, then where does this future lie?
   3. And if not, what might be the long term consequences?

**The care funding crisis.**

Over the last five years, there have been real terms funding cuts of around 9 to 14% in adult social care. The National Audit Office (NAO) has found that some providers were struggling to meet all but the basic needs of users and difficulty in investing in staff training. This has also affected the financial viability of private sector care providers especially the small, local independent providers (local independent providers typically provide about 80% of the market share in many areas). The care sector has raised concerns that up to half the care home market may become unviable affecting a big proportion of people and families using these services. The report provides interesting information regarding how the 'funding squeeze' is having a real impact of reducing the numbers of people accessing services especially for those over 65. Since 2008-09 the number of people over 65 receiving care has fallen by 30%. Overall, for people aged 18 and over, since 2008-09 there are now over 500,000 fewer people receiving care services.

**High level of demand.**

However, there remains a high level of demand for these services. Over the last 10 years, the number of people over the age of 80 years has grown by over 800,000 (it is this oldest age group that is that is the fastest rising; the number of people over 80 in England has more than doubled from 1.3 million in 2004 to nearly 3 million in 2014). Using data from the English Longitudinal Study of Ageing (ELSA), the report calculated that in 2012/13, there were approximately 1.86 million people over the age of 50 with unmet care needs related to their ADL's including dressing, walking across a room, bathing/showering, eating, getting in and out of bed and using the toilet.

**Increasing unpaid carers.**

Reduced access to formal social care means many are increasingly relying on family and friends to provide informal care. The 2011 Census shows an increase in unpaid, informal carers from 5.2 million in 2001 to 5.8 million in 2011 and this increase is faster than the increase in population for that period. About 3.7 million provided 1-19 hours per week, 775,000 provided 20-49 hours and 1.4 million provided 50 hours or more of unpaid care. Women were more likely to be in a caring role, especially those in the age group of 50-64 with 1 in 4 being a carer in this age group.

**Impact of the Spending Review measures.**

While it is hoped that the Spending Review measures will bring an additional £3.5billion into adult social care, the report observes it is difficult to know exactly how this will pan out over the next 4 years. It remains up to the local governments as to how they choose to use their funds, under the new council tax precept, and whether they want to raise council taxes in the first instance to raise additional money for adult social care. Also these changes will take a period of time and in the interim there will continue to be a funding squeeze and significant challenges as funding to local government from central government is being reduced by 56% during the life of this parliament.

**Impact on local authorities.**

The report suggests the council tax precept is likely to actually exacerbate regional and local inequalities. Their analysis has confirmed that local authorities that most need additional funding for care will generate the least amount of funding through the use of the precept. The report calculated what a 2% increase was likely to generate per older person in each local authority in England. This additional revenue per head was then plotted against likely demand for care across all local authorities (measured in terms of proportion of people aged over 65). The findings revealed that the local authorities with the highest proportion of older people will bring the least amount of money for every older person per year. For example, in Lincolnshire's East Lindsey where 30% of people are aged over 65, this would bring just under £30 per older person per year. In contrast in Richmond Upon Thames where only 15% are aged over 65, it would raise £95 per older person per year. This analysis also reveals that there would also be an inverse relationship between reliance and burden on informal carers and the additional funding raised by the precept, bringing in less money where there is a higher reliance on unpaid carers.

The report noted it was of course possible that not all councils would decide to raise taxes under the precept and the King's Fund (an independent charity working to improve health and care in England aiming to shape policy and practice through research and analysis) estimated that the figure of an additional £2 billion for adult social care generated by the precept as proposed by the government may actually be closer to just £800 million.

**Adult social care: towards a new model.**

Even if current levels of spending were maintained, the report suggested that spending on care may reduce from current 1.1% of GDP to around 1% by 2020. Unless further funding is found, social care may become polarised with private formal care available to those who can afford it, alongside increasing reliance on informal carers and increasing unmet needs for those who cannot. While greater reliance on family carers may help to alleviate some of the pressures on formal social care, it does so at the expense of quality and professionalism of care provision and may impact on female employment as women become economically inactive to care for family members. CarersUK estimated the economic value of unpaid carers at £132 billion per year in 2015. Providing informal care puts a lot of strain on the care givers and yet they receive very little support (especially the 1.4 million people who provide 50 hours or more of care per week). Carers Allowance is currently £62.10 per week for those who provide at least 35 hours of care a week (this amounts to about £2 per hour of care provided). There is also a worry that those living alone (the report estimates there are around 4.3 million people aged 50 and above in England living alone) and having care needs may face an even more worrying future with falling levels of formal care and no family or friends to rely on for informal care.

**A 'bleak' future.**

The report concludes that the current changes proposed in the Spending Review do not adequately address the social care needs of a vulnerable population – it does 'little more than paper over the cracks which many of those in need of care are already falling through.’ It surmises an increase in informal care can have adverse consequences not only on the individuals providing care and the quality of care but also the wider economy due to reduced employment. The report advises that if we are going to consider a change in the model of care which is almost entirely reliant upon family and community support, then adequate infrastructure is needed to be put in place to support informal carers. The report ends with concern that with local government facing more ‘severe real terms spending cuts’ it is difficult to see where such capacity is going to come from. The report gloomily and bluntly ends by suggesting the ‘future for adult social care looks bleak.’

This is a very readable report and puts into context the enormity and complexity of the financial funding issues facing the future of adult social care. It is indeed provocative as its title suggests, but at its core appears to send a genuine and clearly thought out evidence-based message about the future of adult social care.

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## Is the biopsychosocial model an illusion? Maxime Taquet

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The biopsychosocial model was introduced to encompass important psychological and social dimensions of illness not accounted for in the traditional biomedical model[1]. Many physicians and medical students recognise the importance of integrating psychosocial factors in the diagnosis and treatment of illnesses[2]. However, some physicians believe that integrating such factors is impractical[3,4], beyond their role[5], or conflicts with their commitment to evidence-based medicine[6-8]. These observations raise an important question: Can the biopsychosocial model be implemented in the realm of healthcare or is it a mere illusion?

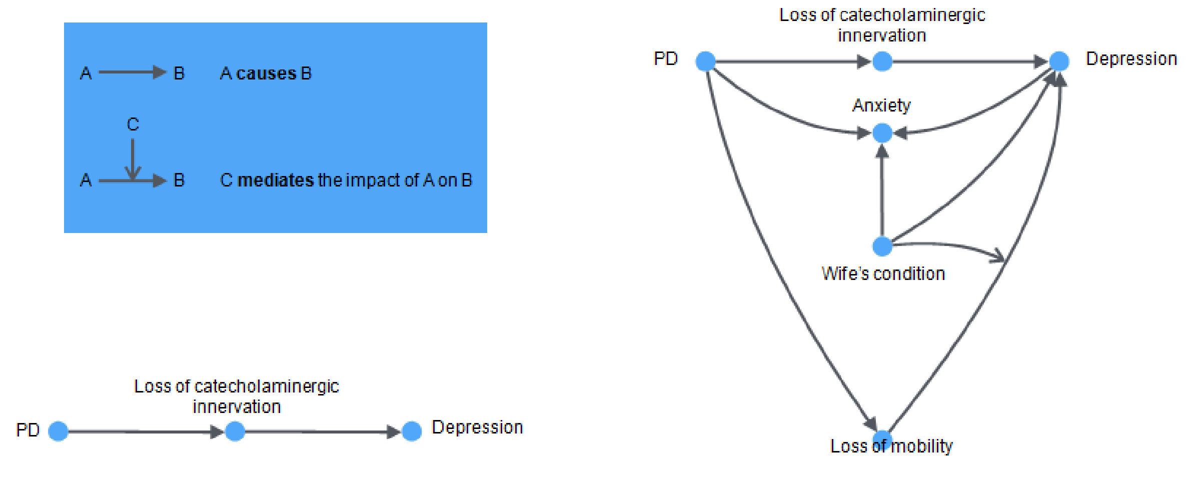
This paper first provides an overview of the models of illness. Arguments expressed against the practicality of the biopsychosocial model are then reviewed and formulated as three challenges related to the nature of illness, the patient-doctor relationship, and the model of healthcare. Each challenge is developed and discussed in the context of Alec Allaway (pseudonym), a 75-year-old retired lecturer with a recent diagnosis of Parkinson’s disease and depression whom I met on multiple occasions.

### Models of health and illness: a critical and historical overview.

Jewson identified three paradigms of healthcare that preceded the biopsychosocial model: bedside, hospital and laboratory medicine[9,10]. In bedside medicine (late 18th century), illnesses were conceptualised as psychosomatic disturbances and disease was defined by patient-reported symptoms and external manifestations rather than biological causes. The doctor’s attention was focussed on the body and mind as a whole and patients’ personal preferences were the main factor driving the management of illness.

Hospital medicine emerged with the centralisation of healthcare and the admission of patients to hospitals in the first half of the 19th century. Illness was conceptualised as local lesions to organs to which the physician's attention was brought. This interpretation of patients as articulated collections of organs was brought by the development of new techniques (notably statistical analysis and structural nosology). Laboratory medicine in the late 19th century followed the development of hospital medicine by further advancing medical technologies and scientific knowledge (notably the development of histology and physiology). In this paradigm, illness was conceptualised as being caused by complex biochemical processes —the biomedical model— that must be elucidated by specialists. Patients were then seen as collections of cells within organs, further limiting their involvement in the management of their illness.

The need for a novel model of illness became apparent for four main reasons[1]. First, the biomedical



(a) (b)

Fig. 1 - Models of illness in Alec Allaway's context. (a) The biomedical model of illness model cannot determine the most appropriate management in chronic illnesses. If the goal is not to captures biological interaction between Parkinson's disease (PD) and depression but fails to capture the complexity of interactions between biological, psychological and social factors. (b) By encompassing different dimensions, the biopsychosocial model embraces the complexity of Alec Allaway's illness, eliciting different entry points to its management.

cure the disease but to maintain pleasurable living, then the physician must account for the patient's expectations, preferences and social environment[11]. Second, the biomedical model assumes a direct causal link between disease (the biochemical defect) and illness (the individual experience of the disease), whereas the biochemical deviation is often one of many factors causing illness and may not have the same time course as the illness[12]. Third, epidemiology studies demonstrated that psychosocial variables play an important role in the aetiology of various conditions including hypertension[13] and stroke[14]. Fourth, it became clear that the communication of symptoms by patients is influenced by psychological, social and cultural determinants that cannot be ignored in the assessment of the patient's illness[1]. Engel introduced the biopsychosocial approach to illness to address these fundamental limitations. In the biopsychosocial approach, psychological and social factors are considered alongside biological ones in the diagnosis of diseases, the management of illnesses and the assessment of outcomes. Because psychosocial aspects of illness involve subjective appreciation, the biopsychosocial approach naturally involves shared decision-making and patient-centred medicine[10].

Importantly, periods governed by different models of illness shared substantial overlaps. The inception of the biomedical model of illness for instance arguably dates back to the 13th century when Pope Innocent III ordered the dissection of a body to define the cause of death[15]. This observation alludes to the main argument developed in this paper: the biopsychosocial model of healthcare is still in its infancy and it is premature to express strong arguments against its practicality.

For models of health and illness redefine the role of the doctor (from honouring patient's requests in bedside medicine to making decisions informed by specialist knowledge in laboratory medicine), the concept of disease (from psycho-somatic disturbances to complex biochemical processes), and the practice of medicine, it should not be surprising that changes in paradigm are gradual processes that evolve from research, through education, to medical practice. Effective integration of the biopsychosocial model in the medical curriculum —let alone its effective application in clinical practice— is still the focus of much recent research[16].

In light of these observations, we shall now investigate three challenges encountered in applying the biopsychosocial model in clinical practice. I illustrate their significance in the context of Mr. Allaway's illness.

**Challenge 1: Embracing complexity**

Mr. Allaway was diagnosed with Parkinson's disease (PD) in 2014, following an earlier diagnosis of depression interpreted by his GP as a possible symptom of PD. The comorbidity between PD and depression has been extensively investigated. Large discrepancies in the prevalence of depression among patients with PD have been reported ranging from 2.7% to 70%[17]. Meta-analyses covering various diagnosis criteria have however confirmed the increased prevalence of depression in patients with PD and estimated it to be 35-40%[18-20].

Albeit exclusively cross-sectional, these findings have led researchers to seek causal mechanisms linking depression to Parkinson's disease. One prevailing hypothesis involves the loss of dopamine and noradrenaline innervation[21,22]. Although such pathophysiological pathways are crucial to guide the development of new drugs, they may also divert the attention from a biopsychosocial account of the illness required to grasp the complexity of the patient's condition.

In Alec Allaway's case, besides the biological link between depression and Parkinson's disease, psychosocial factors also contribute to episodes of low mood and anxiety. When questioned about the reasons for his anxiety, Alec first mentioned about his wife's deteriorating dementia ("When the telephone rings, I always fear that I will hear bad news about my wife"[b] ). The deterioration of his own symptoms only comes second as a source of anxiety, his biggest concern being that he may eventually be unable to visit his wife at the nursing home due to lack of mobility. As became clear during our meetings, assessing Alec's health necessitates to factor in his wife's condition. On multiple occasions, when questioned about his current feelings, he would start by mentioning his wife's. "How are you feeling today?", I once asked. "Good", he answered, "My wife is in a new nursing home which she prefers". The interactions between biological (pathophysiology of Parkinson's disease), psychological (anxiety and low mood) and social factors (relationship with his wife) in Alec's heath therefore present with a degree of complexity. Whereas this complexity may appear daunting or impractical to some[3,4], I believe that it should be fully embraced for it offers different entry points to the management of his illness. Alluding to this idea, Alec once expressed to me that “simply talking through [his] problems already made [him] feel better”.

Arguments against the practicality of the biopsychosocial model call for better guidelines describing its implementation. The current NICE guidelines for Parkinson’s disease (2006) mention the high comorbidity of Parkinson’s disease and depression but only provide pharmaceutical information about its management[23]. Regarding social aspects of the illness, they merely specify that patients should have “access to a reliable source of information about clinical and social matters of concern”. These guidelines are however scheduled to be updated in October 2016. In this context, various stakeholders have expressed the need for a more explicit and comprehensive account of depression and anxiety in Parkinson’s disease (see the Scope Consultation Comments Table of November 2014[24]). The British Association for Counselling and Psychotherapy advocated the inclusion of depression as a symptom of PD. Parkinson’s UK believes that the comorbidity of anxiety and PD should also be recognised and its impact on patients with PD should be highlighted. This charity also urged NICE to provide better guidelines on depression in PD, stressing the poor outcome for the patient and their families associated with such psychological aspects of the illness. Finally, they highlighted the important role played by families in the management of patients and the impact that Parkinson’s disease have on them, requesting that these aspects be integrated in the new guidelines. This request also resonates with Alec’s narrative who was referred to his GP by his daughter to be assessed for depression and who has always concealed his diagnosis from his wife for fear of worrying her. NICE responded to these requests by offering to cross-refer guidelines on generalised anxiety disorder and depression in chronic physical conditions and by recommending, for the first time, use of family-related outcomes (such as Decision Making Involvement Scale and Family Hardiness Index) in assessing PD[24,25].

b The patient gave verbal consent for the direct quotation of any part of our discussions.

The stakeholders’ unopposed requests for a biopsychosocial approach to PD and the rather positive response of NICE to them attest to the willingness of the public, healthcare professionals and policy makers to better embrace the complexity of psychosocial dimensions in Parkinson’s disease. Although practical challenges will inevitably remain after their publication, the updated guidelines will hopefully provide a better framework to help clinicians overcome difficulties in taking into account these aspects in patient’s management.

**Challenge 2: Recognising the doctor’s new role.**

Alec mostly withholds his fears, anxiety and depressive episodes from others including medical professionals as he does not “want to be labelled with depression or anxiety” that he finds to be associated with much stigma. To cope with these feelings, he lives by the motto “Expect the worst, hope for the best”, hoping that he will manage to visit his wife for the rest of their lives while expecting that this will only be possible with intense assistance and at a much lower frequency in the years to come. His unshared fears and anxiety also lead him to sometimes seek comfort in denial, ignoring the likely evolution of his and his wife’s condition. This apparently paradoxical attitude towards his illness, alternating between approaching and denying its consequences, appears to be common in patients coping with physical disabilities and severe illnesses[26]. Patients’ coping strategies tend to alternate between approaching the thoughts of the consequences of the illness and avoiding them (as a reaction to the overwhelming emotional flooding generated by the approach)[26]. This oscillating pattern of coping strategies is particularly present in the early stages of the illness (as is the case for Alec) and is ideally gradually replaced by a state of acknowledgment in which the new threat (e.g. the potential loss of mobility) is accepted. Approaching the consequences of illness may require external resources as they can otherwise overwhelm the patient. Alec acknowledged that talking through his condition and fears did make him feel better and more confident. But when asked with whom he could discuss those aspects of his illness, he could not think of anyone. His wife is unaware of his condition and he does not want his daughters to worry. As for his friends and neighbours, he does not want to share his feelings with them to avoid the stigma of “the anxious and depressed old man”.

His doctor could assume this role as part of the widely recognized triad of ideas, concerns and expectations (ICE)[27]. “Wouldn’t you discuss those with your GP?”, I asked. “No.”, he answered, perplexed, “Why would I? Doctors are only pills pushers.” Until that day, I had always thought that the reason why a patient has unanswered fears and concerns was due to his doctor’s poor communication skills. Alec’s answer struck me as testifying that not only must doctors be trained to adopt effective communication but patients must also recognise the doctor’s new role in managing their illness. While doctors all go through formal training in which new approaches to healthcare can be taught, patients are not trained to recognise these new approaches. Most of Alec’s lifetime has been governed by a biomedical model of healthcare since the earliest traces of a formal and practical teaching of the biopsychosocial model dates back to 1990 at the Rochester Medical Center where Engel was teaching[28]. Unsurprisingly, Alec still perceives that biomedical factors are the only drivers of the patient-doctor relationship.

Besides the slow dynamic changes in the training of medical doctors there coexists a possibly slower dynamic change in patient’s perception of the doctor’s role. Alec’s acknowledgment of the benefits of a biopsychosocial approach however suggests that once repeatedly exposed to it, patients may welcome a transition between the two models.

**Challenge 3: Reconciling patient-centred and evidence-based medicine.**

“Why do you think that doctors are only pill pushers”, I asked Alec. “Because that is what they are good at. That is what they are meant to do” he confidently answered. I understood that what was confusing Alec was that doctors could not possibly be good at eliciting psychosocial concerns and at providing the best possible treatments. The scepticism about the doctor’s involvement in psychosocial aspects of illness may therefore partly stem from the perception that patient-centred medicine (PCM) is incompatible with evidence-based medicine (EBM) to which doctors are committed. Salmon presented cases of problematic doctor-patient relationships when patients present with physical symptoms but no evidence of physical pathology8. Those cases are characterised by doctors refusing to engage in psychosocial aspects of illness without an evidence base for a biological defect. Conversely, Summerskill and Pope reported cases where GPs failed to apply evidence-based medicine in situations where psychosocial aspects appeared more relevant to the patients6.

In patients like Alec, rejecting either of these approaches would be counterproductive if not unwise. EBM and PCM should be seen as complementary rather than mutually exclusive for EBM is concerned with gathering, interpreting and delivering data to guide clinicians whereas PCM is broadly concerned with understanding patients’ perspectives and tailoring treatments to patients’ actual needs[29]. In an influential paper, pioneers of the EBM paradigm argued that external evidence need to be integrated with individual clinical expertise and patient's preferences[30]. To close the loop and reconcile EBM with PCM, some have argued that patient-centred medicine should become more evidence-based[29].

Three interesting lines of research may contribute to bringing a stronger evidence base in patient-centred medicine. First, communication research should be reviewed and extended to identify the kind of communication that is most appropriate to individual patients[29]. Second, subjective variables such as patient's mood and emotions could eventually deserve an equally important place in outcomes of clinical trials. The measurement of such variables may be enabled in the future through experience sampling based on mobile technologies, providing doctors with unprecedented insights into their patients' fluctuating psychological state[31]. Third, the biopsychosocial approach should become an actual model that makes testable predictions. An interesting avenue to address this limitation relies on a system theoretical interpretation of the patient's biopsychosocial realm32. Such formalism should be understood as a framework to test the validity of the biopsychosocial model and not as a new concept that future doctors should become expert in, much like Bayesian statistics is the conceptual underpinning of clinical diagnosis but no one expects of a doctor to compute Bayes' formula every time they see a patient.

These developments demonstrate that the practice of patient-centred medicine is not contradictory to evidence-based medicine but rather that the biopsychosocial model can benefit from an evidence base to further its development.

## **Conclusion**.

In the history of models of illness, the biopsychosocial model is in its infancy and receives considerable attention to improve its integration in the medical curriculum and in clinical practice. This process is necessary gradual since changing the model of illness has an impact at every level of medicine from the patient-doctor relationship to the definition of outcomes of clinical trials. The existence of challenges in its practical implementation should therefore not be surprising and cannot be be used as an argument in and of itself against the practical usefulness of the biopsychosocial model.

One such challenge concerns the complexity of the interrelation between biopsychosocial factors of illness. In the case of Parkinson's disease, policy makers, public institutions and charities alike have called for a better integration of biopsychosocial factors in the NICE guidelines demonstrating that incorporating biopsychosocial approaches in clinical practice is still a work in progress. Another challenge is in the recognition of the doctor's new role in eliciting and addressing patient's concerns. This new role must be acknowledged not only by medical professionals but also by patients. This transition will take time since many patients with chronic illnesses, as Alec Allaway, have experienced the biomedical model of illness for most of their lifetime. A third challenge pertains to the apparent incompatibility between patient-centred and evidence-based medicine. This contradiction is misleading since evidence-based medicine has always recognised the value of patient-centred healthcare and, more recently, interesting research has focused on building evidence for the value of the biopsychosocial approach to healthcare.

In the management of Alec's illness, embracing these challenges proves very beneficial. His illness cannot be reduced to biochemical processes for his biggest concerns relate to his wife's own condition and the possibility that his illness may affect his relationship with her. Preserving the actuality of this relationship must therefore be the central goal of any treatment or assistance. Achieving this goal would also require encouraging him to share his fears and anxieties to soothe them and avoid long episodes of denial. He should rest assured that, in doing so, we are not neglecting our commitment to providing him with the best available treatment. Future research on evidence-based patient-centred medicine may even prove that the best available treatment implies that we talk through his concerns and fears.

More than a illusion, the biopsychosocial model of illness therefore appears to be a project under active development that is worth pursuing in patients who, like Alec, suffer from a chronic illness and hope for so much more than a mere pharmacological management of their disease.

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## Welcome to Our World: A collection of life writing by people living with dementia. Edited by Liz Jennings, Forget-Me-Nots, Canterbury. 2014, £5.00 (pb) 256pp ISBN 978-0-9930742-0-2, Reviewed by, Emma Prendergast

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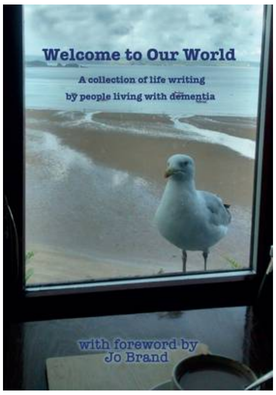

This collection of short stories is provided by a group of individuals living with dementia and came as a result of participating in a life writing course whilst attending the Kent Forget-Me-Not support group. The course was led by author, Liz Jennings and the project was funded by DEEP (Dementia Engagement and Empowerment Project), the contributors were supported by psychology students. This work presents the very fascinating life stories of eight individuals who all have a unique way of capturing your attention, which leaves the reader wanting to know more of their stories! The contributors allow the reader an exclusive look into their most memorable life experiences depicted in an honest, warm and often humorous manner. The stories evoke a range of emotions which lead to reflection of one's own life journey whilst allowing the reader to see the uniqueness of a person's life experiences and emphasises that life goes go on after a dementia diagnosis. All eight stories emanate pride and praise of the work, companionship, and support gained from attending the Forget-Me-Not group.

As a clinician working with people living with dementia this collection of stories provided an insightful perspective into the world of dementia and the effects it can have on the person diagnosed with the illness and their families. It is enlightening to see the strength and determination of the group to work on projects relating to dementia issues which it aiding in bringing about improvement in services , policies, funding and research. The Contributors and all working on the project challenge the traditional perceptions of dementia, as a condition of loss, and demonstrate much can be gained after diagnosis. The reflections of the contributors living with their dementia makes it a useful read for all including health and social care clinicians and people newly diagnosed. It will provide the reader an understanding of the initial stages of memory and behaviour changes exploring their thoughts and experience of life after diagnosis.

## Everything can always be better than it is - reflections of an Old age Psychiatrist: Dave Anderson

### A change can be better than a rest.

I became a consultant in 1989. It was a 29,000 catchment population, one community nurse, one first year SHO (Carmello Aquilina, creator of the Newsletter) and a secretary. 2 consultants sharing 30 bed functional and 30 bed dementia assessment wards, no social worker, OT, psychologist or physiotherapist, 300 domiciliary visits per year done between 5-8pm most days, 20 mixed dementia and functional day hospital places in a basement room with no windows, one office and a toilet and 30 long stay dementia beds in the grounds of the old mental hospital in a wooden structure declared a fire hazard by the fire service 5 years earlier. I started seeing new referrals at home, arranged weekly meetings with the district social work team to access social services and I loved it. We routinely saw people in dire circumstances, which is rare now.

My last post, catchment population 10,000, 3.5 community nurses, OT, psychology and physiotherapy, 5 consultants share a 20 bed functional and 15 bed dementia assessment wards, the day hospitals and long stay beds have gone (this wasn't the catastrophe some predicted), little need for paid domiciliary visits (referrals seen in 3 weeks), the first memory service to receive College accreditation with excellence, a multidisciplinary liaison psychiatry service (and the acute hospital now has 4 nurses dedicated to dementia care and learning disability), 7 day community team until 9pm, Post Diagnostic Support Groups for patients and families, cognitive stimulation therapy groups, partnership with a famous local Football club and Museum of Liverpool running reminiscence groups, access to a gym for dementia patients, a dementia alliance and large dementia user and carer reference group involved with all strategy which is changing attitudes within the city, a collaborative dementia clinical network with geriatrics, neurology and primary care, care navigators, an integrated physical and mental health frailty service. Older consultants who insist it was better in their day really haven't been paying attention. But its clinicians who made these things happen.

Sadly, there has not been parallel progress in social care which I think has gone backwards, and ironically, when integration became a political imperative our previously integrated service was disintegrated. The relationship between health and social care must fundamentally change.

**The big changes.**

Since we became an NHS specialty (1989) the three most important changes, for me, have been the revolution in liaison psychiatry for older people, the National Dementia Strategy and the Equality Act and I was lucky to be involved with all three.

In the late 1990's I met John Holmes in Leeds to find we had a common interest, general hospitals. We couldn't understand why nobody seemed concerned about the size & importance of the older peoples mental health morbidity in these hospitals. Liaison psychiatry was a general adult specialty, their job description said people over age 65 were the responsibility of old age psychiatry but old age psychiatry had nothing to say about it. We lobbied, wrote, spoke, prodded the College and Department of Health and started an annual multi-professional conference in 2001. In 2005, we published a document called Who Cares Wins stating the case of need which was to prove highly influential in changing attitudes at home and abroad. It was conceived and produced with some interested friends in an OT room in the Manchester Royal Infirmary, since demolished.

When we started there were virtually no liaison services for older people just a handful of lone practitioners mostly unsupported, untrained nurses and by 2011 the National Audit of Dementia in General Hospitals, which I was involved with and an important initiative in its own right, reported they were available in 75% of acute hospitals. I started the liaison service for older people in the Royal Liverpool University Hospital in 1998 (without any funding in the early years) and the change in attitude to mental illness in the hospital is extraordinary. That culture change can only be achieved by a liaison model because you can only change culture from within. We must ensure it remains part of old age psychiatry because, now successful, others will claim it.

The National Dementia Strategy was an amazing project and changed everything for people with Dementia. Sube Banerjees dogged determination, as Specialty Advisor to the Department of Health and co-author of the strategy, to make this happen was impressive. It was now a condition at the top of the political agenda, later adopted by the Prime Minister. I cautioned about the danger of divorcing dementia from the rest of mental health and so a section was included in the Strategy emphasizing that it should be part of an integrated approach to mental health by older peoples mental health services. Sadly, I don’t think many people read that part.

The Equality Act is momentous for protecting older people from discrimination. It is not responsible for “ageless” services ( a ridiculous term, nothing is ageless, rather, age is now a personal characteristic in law) which were already appearing and I wrote to the Secretary of State, NHS Chief Executive and National Clinical Directors and met the Minister about this in 2007. The same year we published a joint statement with the General Adult Faculty opposing this approach. But, every organization with an interest in older people had established their position that we could not continue to treat people on the basis of age not need. Geriatric Medicine had made those adjustments claiming important niche areas in health care (we need to do this), its status has risen and corpus expanded. The Old Age Faculty was becoming isolated by defining itself exclusively by age and we had to change. We did, and produced a College Position Statement in 2009 on needs based equality in mental health which we launched in the Palace of Westminster to universal acclaim. That services in mental health should be non discriminatory but age and developmentally appropriate was then enshrined as a principle in the National Mental Health Strategy and our new position gave us the credibility to influence that wording. Older people now have a right to access any service that best meets their need and they couldn’t before.

Let us not forget that age discrimination in the health care system was greatest in mental health. We pointed out that this arose not from service configuration but from the way national policy had been produced and, now, with the Equality Act, this should not happen because policies and implementation would have to be equality assessed. OPMH had been excluded from the heavily funded mental health strategy, lost and unfunded in the older peoples strategy. A single national lead for OPMH was needed and I wrote to the Secretary of State in 2007 urging the creation of a National Clinical Director responsible for mental health in older people not just dementia (Sube Banerjee had already made the case for the dementia Csar) and, since 2015, we have one.

**Ideas, Endeavour & stop moaning.**

Chairing the Faculty (2006-10) was an absolute joy but very hard work. That period saw developments of such enormity and we had to be involved with it all. And, use any levers, relationships & political opportunity that we could. I have never read so many reports, strategies, policies & guidelines which were flooding from so many organizations about older people and mental health. And, we produced many ourselves. Nor had I attended so many meetings or spoken at so many conferences or spent so much of my life on trains and planes. The momentum for change in so many aspects of OPMH had become huge and absorbing.

In that time I was lucky to work a lot with NICE. In 2006, I joined the Mental Health Topic Selection Panel exclusively to persuade NICE to develop a Delirium Guideline because general hospitals were not attending to this serious condition at all. The selection panel didn’t back it but the NICE secretariat saw the added value this guideline offered the NHS, asked me to produce a briefing paper then recommended it to Ministers and it happened. NICE health economists found its implementation would save money (unique for a guideline at that time), an example of better care costing less. This was, personally, a gratifying success (and an example of finding levers for change) because the improvement in general hospital practice has been substantial though they have yet to fully grasp preventative interventions. Now Delirium is part of a national CQUIN. Later, I was involved with production of Quality Standards for Dementia & Delirium putting them on the commissioners to do list.

In Liverpool I was Head of the School of Psychiatry implementing Modernising Medical Careers (a fiasco but fun) and Associate Medical Director implementing medical appraisal, Revalidation and job planning. All big change and getting involved with new things, especially big change, is always interesting and fun. The more one gets involved the more interesting it becomes. It forces one to think deeply, teaches one about people, systems and ideas and improves personal skills. When I was a Clinical Director, I discovered that the doctors who moan and complain the most (and boy can some of them moan and complain!) are the least likely to get off their chairs and find solutions. And, while it is possible to achieve things without extra resources and funding (and it is) it is never possible without ideas & endeavour. Change is inevitable, you can either sit on your chair and moan or get off it and influence its direction.

When I look back at that period the progress is remarkable. While there have been disappointingly few new insights into the nature of the disorders we treat our ability to deliver better health services to patients and their families is impressive. The elderly will remain high on the political agenda which I am glad about now that I am closer in age to my patients than most of my colleagues!

I so envy young doctors entering this specialty because the possibilities in front of them are truly exciting. To be involved with the biggest global health and social care challenge that is ageing populations and finding solutions has to be as good as it gets. Would I do it all over again? I wish I had the chance. And if we want to attract those young doctors we must enthuse them with questions, ideas and change, stop moaning and show endeavour. Who is going to be inspired by disenchanted, moaning doctors? These were not the people who inspired me. The status quo is never good enough because everything can always be better than it is and we need young inspired doctors who can prove it and who don’t fear change.

## My career in psychiatry – chance and opportunity, Dr Vicky Banks

I have reflected on my journey in psychiatry, some of the decisions I made and the paths I followed. Few were planned but made through chance experiences and or opportunities. I have made the most of these, sometimes with uncertainty and not always with success.

I have enjoyed my career enormously , yes there have been ups and downs but it hasn't dampened my enthusiasm, energy and drive. I have met and worked with so many individuals, patients and professionals, all with their own stories and journeys who have all helped shape and develop me into the doctor I am today.

I have reflected on a parallel journey that I have been travelling throughout my career as a psychiatrist; that of daughter and wife i.e. a relative and carer. These parallel roles have strongly influenced my practice.

As a senior registrar, visiting Dr Brice Pitt with my father with his early onset dementia, his inexorable, painful and distressing slow decline as he recognised his lot before his behaviour necessitated a continuing care bed. The challenges of being a relative and not the clinician opened my eyes to the challenges carers face in getting the right help and support.

During this time my husband became unwell and didn't survive, another carer role that on reflection influenced my approach and the relationships I had with patients, carers and teams. As two journeys finished so another began – my mother's mixed dementia, living alone, her vulnerability and lack of insight, needing to fail the driving test to move on; you will have heard it all before. Her move to a local nursing home was relatively easy, she was just visiting, as she had done over the years for friends and neighbours. Acute hospital admissions followed and the challenges those brought as a carer not a doctor were both enlightening and frightening . Even the advanced directive and DNR didn't stop the resuscitation attempts. As a doctor I thought I could help her avoid some of these pitfalls – it was very hard. So how hard is it for our patients and carer?

So where did it all start? I never really imagined I would become a psychiatrist. My initial thoughts were of marine biology and aero-engineering, but eventually thought I would become a doctor, having researched marine biology and discovered that there was a risk that I may become a secretary. Definitely not on my list!
At a reunion 3 years ago we were all discussing our careers and someone commented that they knew I would be a psychiatrist . “How” I wondered as it took me a lot longer to get to this point:

Psychiatry as a medical student and the beginnings of a relationship with dementia.

At the end of my training and my first night on call required the support and management of an elderly lady with walking stick with dementia – and the introduction to thioridazine.
Career uncertainty led me to a GP scheme in Lee on the Solent which included both psychogeriatrics, and oncology the other career I thought I might like to follow. This opportunity of a three year rotation of jobs was the best introduction and preparation to being a doctor there was, I learnt a lot about myself and how I might develop. We had long considered voluntary work before developing our careers further and applied to Voluntary Service Overseas (VSO). I had developed my practical skills in orthopaedics, obs and gynae and primary care to support work overseas.
VSO did not need us!! So another opportunity arose – go and work in New Zealand.

But what to do? ‘Simples’ as they say Psychiatry 2 exams vs Oncology 4 exams.

Off to NZ to work in psychiatry – a revelation, multi professional teams, leadership and learning. Joining the crisis team led by a psychologist and supervised by social workers, nurses and psychiatrists was inspirational and inspired me throughout my career. If I could work with teams like this who made such a difference to patients lives then psychiatry was definitely the right career for me.

Back to the UK: Solent rotation in Southampton/ Hampshire – very different models of teams here. Somewhat disillusioned but determined to continue to find the perfect team model. So psychotherapy, acute adult, forensic, community and then Psychogeriatrics at Moorgreen Hospital with Consultants Colin Godber, Henry Rosenvinge and David Wilkinson and great teams. This is what I had been looking for; teams working with patients , families, carers and other health professionals. Perhaps in those days paternalism was still a strong feature of the teams but became less so as time went on. Those were also the days of ECT at 7.00 am with long lists three times a week. SSRIs just starting to find their way on to the prescribing list, perhaps influencing the future of ECT.

So Psychogeriatrics and teams for me. As membership loomed a study group developed, a close group, three of us becoming old age psychiatrists who I have continued to work with over the years.

Passed!!

Next stop Senior Registrar in psychogeriatrics in Bristol. More development of teams and different models of working. Influential consultants, Ihsan Mian, Mike Nowers, Rica Newbury and Julie Parker who really helped me think about issues in a different and more human light. The start of regular supervision and the Record of In Training Assessment (RITA) process. I had a role in the college trainees committee, so an ear to the ground about other services and opportunities.
A short spell of adult psychiatry reminded me that Psychogeriatrics was the right choice.
So to Psychogeriatrics at Knowle Hospital in Fareham. Population 20,000+, referrals up to 10/week, one long stay ward, functional beds, day hospital, organic assessment beds and a community team and a supportive group of colleagues to work with; fab job, great colleagues.
Day one: appointed as college tutor – my career in medical education had started.
Organisational change, “care in the community” arrived and we moved into the community hospital. A major opportunity to strengthen our relationship with Geriatricians, GP unit, local social services and GPs. Chance discussion led me to start a regular clinic in the practice where I had been a GP trainee! So more communication with GPs, easy access clinics and better care for patients.

The Community team developed expertise and confidence in undertaking assessments, a major step forward.
Now in medical education my tutor role was developing, working with trainees, appointing doctors who over the years have become my colleagues and friends. It has been an enormous joy to see them develop and flourish into the psychiatrists they are today.
Organisational change and a chance opportunity at Moorgreen – the spiritual home of OPMH in Wessex. So another change, opportunities and challenges to be embraced.

Opportunities also mean moving on and leaving others behind; a real sadness.

New patients, colleagues and teams, new expertise, the research unit, memory clinic, an opportunity to support and lead the liaison service, develop the intensive support service funded through bed closures, take on the lead clinician role, develop my role as an appraiser. I saw these as opportunities to improve our service for patients.
I moved clinical roles more frequently to support our changing services and patients' needs.
Inpatient consultant, work with nursing homes, supporting teams and families in the closure of long stay beds, clinics in surgeries continuing. On a couple of occasions walking through snow to do a home visiting clinic on foot with one of the nurses.
In 2007 the schools movement and Modernising Medical Careers were rolled out and I immersed myself as Head of School in medical education, ARCPs, the College, trainee recruitment, development of the e portfolio – loved and hated in equal numbers, the interface for the ARCP. Locally we developed a learner centred MRCPsych course and the professional programme for senior trainees.

As Associate Dean for higher training I supported the college with the concept of an end of training assessment, an opportunity that didn't quite come to fruition. Working with the trainees and other heads of school I believe I made a positive contribution to the quality of training in psychiatry.
My greatest achievement for local training was the appointment of one and then another Psychotherapist in 2013 after years of plotting and planning.
Organisational change offered me more opportunities developing my leadership roles in mentoring, appraisal for the trust and college, clinical leadership and organisational development. Then to lead on revalidation as Deputy Medical Director before a period as Responsible Officer for the trust led to an interface with the regional team. The next opportunity was in gestation!

July 20*13 – 55- retirement! Freedom*
*Back to* New Zealand and travelling in all black World Cup rugby Camper van. Reminiscence and reflection.
I retired from my consultant role and a life of dementia hoping that I have made a difference to those I have worked with; patients, teams, trainees and families.

I have embraced change and opportunity to influence improvement across health care.

My life with dementia and death has influenced my passion for great patient care.

So the next step- Associate medical director for quality and revalidation for NHS England South. Opportunities abound, working with a great team to support doctors, develop leaderships and influence national work on revalidation and appraisal.
My role has a strong focus on working with patients, improving the impact of lay involvement in the development and support of doctors in partnership.

Still going – where next?? What opportunity??

## Tips on writing for *Old Age Psychiatrist,* : Editorial Team, Old Age Psychiatrist.

**Helen McCormack, Anitha Howard, Sharmi Bhattacharyya, Ayesha Bangash**

The comments here are based on the combined experience of current and previous editors of *Old Age Psychiatrist* (*OAP*). We receive many articles on important subjects, but some are badly written. In particular, they are too repetitive, are poorly structured, and grammar is often incorrect. Others have no direct relevance for psychiatrists working with older people.

**Suggested types of article:**

- Innovations / interventions which have or have not worked.
- 'The spice of life'
- 'How to survive the current round of NHS changes'
- 'The best thing I've done in the last month' (work related!)
- Case studies: they are not accepted by many journals, but for some people they can be thought provoking and a good way to learn. Case studies must be accompanied by a statement of consent from the patient or their representative and must be anonymised.
- Reviews of relevant clinical and research topics not readily found in text books or academic journals.
- Reviews of books, films and websites.
- Someone who has inspired you.
- Recent experiences and papers read recently: what has inspired, angered or influenced you which other people should know about?

**What we do not want:**

- Clinical research
- Papers with masses of statistics
- Audits

These should be published in peer reviewed journals.

**Please do not** send articles to more than one College newsletter! If an article is relevant in more than one Faculty, we can include a link.

**Word length**

500 to 1,500 words is good.

**Illustrations** are welcome, provided they do not infringe copyright.

**Submission**

Please use Microsoft Word and e-mail the article to us.

**Include**

Title
Names of all authors
Contact details
Page numbers

**Style**

We can be flexible about style, but **please be consistent**, including with capitalisation, referencing and punctuation.

**Tips on writing**

- Use language which shows you are passionate about your subject.
- Most of us have to put time into our writing. Regard your writing as a piece of art which has to be perfected to have the right impact.
- Sometimes finding the right words is a bit like pulling teeth. On line or Microsoft Word synonym finders can be very useful.
- Use a word processing package which automatically checks grammar and has a spell-checker set to UK English.

- Is your argument crystal clear and logical? Readers will want your message 'up-front' and will not have the patience or time to search for your meaning. Use headings to help structure your argument.
- Do not send an article to us it to us the second you have written a first draft! Put it away for a day or so, re-read it, and think about the style, the argument and the message you are trying to put across and improve it. Do that a few times. Get someone else to read it through and give you feedback. You may know what you are trying to say, but that does not always come across.
- Avoid words like 'obviously', 'certainly', 'clear' etc – if it was all so obvious there would be no need for the article.
- Weigh up the pros and cons of using 'patient', 'client' or 'user' in the specific context of your article. They are not synonymous!
- Define all abbreviations and acronyms: *Old Age Psychiatrist* (*OAP*) is read by old age psychiatrists abroad and by people in other disciplines.
- Write concisely e.g.
    - 'He was' rather than 'He appeared to be'
    - 'He walked' rather than 'It was also reported that he walked'
    - 'He described' or 'He told us' rather than 'He also gave further details regarding'
- Use positives rather than negatives: they convey more information and are less wordy e.g.
    - 'They had little contact' better than 'They had not had much contact'

**you are writing a book (or other) review:**

- Please give full details of the book including author, title, publisher, page length and cost, if not available free on line. Please give website if it downloadable.
- Try to make the first couple of sentences engaging for your reader.
- Say what the book is about and who it is for. There is **no need to summarise the whole book.**
- Point out strengths and weaknesses, things you liked or disliked.
- Give examples to back up your comments, both positive and negative.
- Does it fulfil its stated objectives? Is it targeted at the right audience? If so, why? If not, why not?
- Who would you recommend to read / buy it?
- Would you re-read it? Dip into it again?

**References**

Not all articles need references.

Consider if they will add to your article. If so, a little bit of effort in referencing to substantiate your arguments is well worth the time.

Please ensure that you have read and understand the article cited, not just the abstract!

Your style of referencing must be internally consistent. That includes layout, punctuation, abbreviations, use of italics. If you need a format to follow, then use the style of the *Psychiatric Bulletin* http://pb.rcpsych.org/site/misc/ifora.xhtml

**Revising your article**

Some of the articles we receive are sent for peer review, others are just read by the editors. Most will require some revisions, once or twice.

Most people regard their writing as good and hate making revisions, but please make the changes the editors suggest. Don't just skip over them!

If you disagree with our suggestions then tell us.

Please ensure that the up-dated, corrected version is e-mailed to us.

**Useful reference about writing**

For some good, brief tips, see Tim Albert, Getting published: 10 things to do before you sit down to write, *BMJ* (13th October 2012) http://careers.bmj.com/careers/advice/view-article.html?id=20009242

**Mind your language … or 'Let's abolish "the elderly"'!**

As Professor Bernard Isaacs wrote in 1982: 'Let's abolish "the elderly"' *BMJ* (1982) 284: 112 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495641/

Introducing a heterogeneous group of people with a homogenising definitive article is unacceptable!

*Dementia words matter: Guidelines on language about dementia*, produced by people with dementia in the Dementia Engagement and Empowerment Project (DEEP).

http://dementiavoices.org.uk/wp-content/uploads/2015/03/DEEP-Guide-Language.pdf

This is an excellent, highly recommended, brief resource on writing about dementia.

The journal *Age and Ageing* gives relevant guidelines on language:

'Try to avoid language that might be deemed unacceptable or inappropriate (e.g. 'older people' is preferred to 'the elderly', the word 'senile' is best avoided). Take care with wording that might cause offence to ethnic or cultural groups.'

http://www.oxfordjournals.org/our_journals/ageing/for_authors/index.html

We hope you will find these tips useful, and by all means give us your views.